

**THE CONDUCT OF MEDICAL
PRACTICE**

THE CONDUCT OF MEDICAL PRACTICE

BY
THE EDITOR OF "THE LANCET"
AND
EXPERT COLLABORATORS

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PREFACE

THIS book incorporates, in whole or in part, many of the articles which appeared in the *Lancet* recently under the common title of "The Conduct of Medical Practice" Some of the articles were signed and those are reproduced substantially as they were written, only such modifications occurring as were due to the inclusion in a continuous story or to the need to avoid overlapping

Dr James Neal, Secretary of the Medical Defence Union, is responsible for Chapters VI, VII, IX and XIX, and Dr. Hugh Woods, Secretary of the London and Counties Medical Protection Association, for Chapters X, XXII, XXIV and XXV The circumstances which attend the entrance upon or the acquisition of a practice are set out in these chapters, as well as the difficulties, professional and legal, which may present themselves to the practitioner From these contributions the absolute need of adherence to one of the Defence Associations becomes clear

The anonymous author of *Panel Practice* has collaborated in the section describing entry into practice The chapters on certification and prescribing in insurance practice were written by Mr Shoeten Sack, joint author of *Medical Insurance Practice*, and that on the transfer of practices by Mr C M Oliver and Mr O A Hempson, Solicitors to the British Medical Association We owe to Dr G Roche Lynch the exposition of the relations between the doctor and the coroner, and the chapter on suspected poisoning The Appendix upon account-keeping and income-tax assessment was written by Mr W R Fairbrother, F S S

Others who have rendered valuable help are Mr G S Elliston, editor of the *Medical Officer*, Mr Norman King,

Registrar of the General Medical Council, Lady Barrett, Mr Harold Beadles, Dr J Blomfield, Professor E L Collis, Dr J N Dobbie, Prof H W L Duckworth, Dr G W B James, Dr Bedford Pierce and Dr Meredith Richards. These names do not exhaust the list of cooperators, and real gratitude is expressed for such liberal and expert help.

May 1927

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THE CONDUCT OF MEDICAL PRACTICE

PART I

THE MEDICAL CAREER

CHAPTER I

INTRODUCTORY

The Golden Rule—The Professional and Commercial Attitudes—The General Practitioner's Needs

THE practice of medicine cannot be regulated in accordance with a code of rules devised to meet all situations, and the situations in its practice seldom arise in a definite manner, or with any frequency which can be anticipated in the experience of particular men or even of a particular group of men. There are usual and unusual happenings, but their outcome differs with the position of the practitioner, who is pursuing a progressive calling, and one that is affected by, and affects, its whole environment. For the medical life mirrors in a sensitive manner social positions that are always altering, while on its scientific side it is informed throughout by lessons drawn from knowledge that is ever progressive, and experience that is ever widening. It follows that the comparative importance of many of the problems which present themselves in the conduct of medical practice is constantly changing—what appear to be mere points of detail become later essential matters, broad conditions are modified and subdivisions disappear, while completely new matters are introduced, now by developments in learning, now by legislative reform, and now by general alterations either in social circumstances or mental outlook.

This volume deals with the conduct of medical practice, and not with the conduct of practitioners. It includes much of a series of chapters which have been appearing in the *Lancet* for some time under the common title of "The Conduct of Medical Practice," but does not pretend to be a manual of "medical etiquette." There are sections of the public who may still believe that medical men are guided in their behaviour by a set of quaint and secret rules designed to maintain medical interests at the expense of the popular purse. The view formerly received confirmation from the fact that some medical men appeared to want to regulate their behaviour towards each other and towards the public by an elaborate code designed to meet any professional questions that might arise, and many of us can remember treatises purporting to define that code. The treatises—two at least of them—were well written, they formed useful guides to many in situations of difficulty as they were wont to present themselves, and they inculcated a very proper spirit for the preservation of just professional interrelations. But they had their danger when wrongly used. They were written as an indication to medical men of right mutual behaviour, and when a practitioner insisted in regarding them as laying down regulations by which the public must be guided, whether the public understood them or no, trouble always occurred. To-day it is probably sufficient to say that obedience to the dictates of medical ethics implies application to the ordinary chances of professional life of the excellent rule that a man should do as he would be done by. If it became natural for the public to see that the gist of medical ethics lies in that axiom, the medical attitude in public affairs would be better comprehended.

THE GOLDEN RULE

Aphoristic by-laws designed to meet special cases are often useful, and it is not intended to decry the value of the codes that have been published, but such books mislead the professional man as much as the public, by causing both

to think more of special instances than of general principles. Take for example this common situation. A medical man is in attendance upon a patient who desires to employ somebody else. The patient finds that there is difficulty in obtaining the services of a second medical man who, though prepared to assist in any emergency, declines to take over the case save from the hands of the previous medical man. The patient complains that obstacles are placed in the way of obtaining the medical advice that he wishes to have, and blames "medical etiquette." It is a fact that formerly some medical men wrote and spoke as if they believed that, having once been called in to see a patient, they had obtained a vested right in that patient, and could on no account be dislodged from his bedside, but the freedom to choose the doctor is a fundamental principle in the administration of the National Insurance Acts, and should be welcome in all branches of practice, for nothing should be allowed to intervene between a patient and his choice. But it remains advisable in the interests of the patient that the second practitioner should not attend until the first has been definitely discharged from the case, and until the second has received from the first a statement of the circumstances. The reason for this is obvious. The patient being without medical equipment cannot know that the treatment, which is apparently doing him no good, is the wrong treatment, and cannot tell even what that treatment has been. If the second practitioner does not formally take over the case from the first, he is treating the patient without being in possession of the facts necessary to make a diagnosis. He does not know what has been done or left undone, and he may be without an essential part of the medical history, namely that appertaining to the early appearance of symptoms. If the case goes well the second adviser will obtain credit at the expense of a brother practitioner which may not be deserved, and, mark, he will obtain that credit even though he repudiates its justice. If the case goes ill it may be considered that the preliminary mismanagement by the first

medical man has dictated the bad issue, when in fact no such connexion could be established

This is an example of a common situation, selected because it is one where an ill-directed action brings no good to anyone, for if the first doctor must be considered to have lost a client, and to suffer materially in more than one way, the second is handicapped in his efforts to ascertain what is the real trouble for which the patient desires relief. But the supersession of the regular doctor is attended with many circumstances of delicacy. Nothing must obscure the fact that a patient can choose what doctor he likes, but the successor should not comment upon his predecessor's action. It is therefore awkward if the successor should happen to be a private friend of the patient, and to have paid him visits of a neighbourly character during his illness. Hence such visits should only be made where the practitioner in attendance sanctions them. Emergency patients must be handed over at once to their own doctors, and if questions arise out of the patient's expressed desire to remain a client of the practitioner summoned in an emergency a frank discussion should take place between the parties concerned, and it is often useful to seek the opinion here of a recognized leader of professional thought.

Other situations could be brought forward in manifold variety where formulæ have been constructed to perfect the interrelations of medical men, but in most cases the course of conduct is indicated by a simple answer to the simple question, "How would you like it yourself?" There is the setting-up of multiple addresses, when a practitioner arranges to be present or to receive messages at a spot within an area where the majority of the population employ a fellow practitioner. This action is liable to censure, but it may be a response to a public demand, and is a good instance of the impossibility to frame with justice either a disciplinary rule forbidding multiple addresses, or a general endorsement of their employment. What in past days may have been construed as unethical can no longer be so regarded. There is no sense in regarding the use of mul-

multiple addresses as an ethical offence in view of modern methods of transport, which make all districts within ten miles of any doctor's house perfectly accessible. If patients desire to see a certain doctor at a certain spot, he cannot be held to have committed an unprofessional action when he facilitates their wishes, but he can enter into amicable discussion with any colleagues or professional firms before taking a step at which they might look askance. He can show them that he is not employing cutting-out tactics, but rather is falling in with the exercise by the public of the right to choose the doctor. He should not act without communication with his colleagues, and he should certainly not delegate new outlying work to a new assistant, for such action could only be interpreted as the establishment of an outpost with a view to extension of territory. The offence of multiple addresses is one of which we shall probably hear less in the future—already complaints in this respect are becoming rare in the columns of the *Lancet*.

Those who receive unusual publicity in the daily press are so often sinned against that no by-law on the subject could be administered without chances of injustice. It is recognized now even by the most censorious that the doctor cannot prevent his name from appearing in a newspaper when he plays a part in an episode which the press considers to be "news," and with this concession there has disappeared much fault-finding in respect of, for example, the presence of medical men on public platforms, the signing of bulletins in connexion with prominent invalids, and to some extent the writing of letters to the lay papers. These things used to be considered definite offences against professional spirit, and warnings against them were issued without any discrimination. No attempt was made to find out how the offending publicity occurred, and if a letter to the public press was in question no distinction was drawn between a communication conveying wise public teaching and one suggesting the possession in the writer of unique talents, similarly, to speak at a temperance meeting was regarded as canvassing for patients, and not as proselytizing.

ing for health, while practitioners were suspect who read the lessons in church. We take a fairer view of these matters to-day, and no attempt can be made to lay down professional rules for the prevention of offences that cannot be defined, and for the infringement of which, by the way, there can be no penalties unless the General Medical Council is asked to intervene. But the absence of formulæ does not imply any approval of the conduct of medical men who bring themselves indirectly before the public as authorities so variously as to preclude the possibility of their views being always especially valuable. The seizing of every opportunity to instruct the public may be due to pure desire to afford valuable information, but the spread of education has levelled up general culture and the temptation to pontificate should have disappeared. And need it be a temptation? Need the conviction be strong that the world will suffer from silence? Johnson said that the lexicographer was "exposed to censure without hope of praise," and the medical contributor to the press is usually in like case.

THE PROFESSIONAL AND COMMERCIAL ATTITUDE

The following chapters consider the conduct of medical practice, taking note of the situations of difficulty which arise, so that the practitioner may be prepared to act for the best in the public interest as well as in his own, and in accordance with a correct professional spirit. That spirit is supposed to mark the distinction in relations which may properly exist between those who are working on commercial lines, and those who are following a learned calling. The distinction is usually defined by one simple example, and there is no reason to look about for a better. Thus it is correct for individuals or firms to advertise to the public that they sell something which is better or cheaper (or both) than any similar goods sold by any other individuals or firms, for the public can try out the claims. But it is wrong for a doctor to convey to the public that he possesses a method of therapeutics that is better or cheaper

(or both) than any method possessed by his fellow practitioners, if only because the public cannot sift the evidence for the claims. And this cannot be done, because in the majority of the conditions for which medical advice is sought the total of those conditions is not known to the public, nor the origin of all of them, nor the influences of one condition upon another. So that the public can never tell how far any particular treatment has dealt adequately with the whole case, or, indeed, what the whole case is. A statement by those who sell particular goods for particular purposes can be investigated by the public, who can judge how far what has been advertised fulfils the vendors' assertions, but it is wrong for a medical man to assert to the public that he has a treatment for some disease which is superior to any other offered, because the public, not knowing the real significance of the symptoms, their relation to causes or their comparative importance, and not understanding that the same things may be symptoms or concomitants of many conditions, will go to that medical man for relief, when there is no proof satisfactory to medical knowledge that he possesses any special qualifications for affording it. It is among fellow practitioners that any claim for therapeutic success should be made, because they are in a position to understand the arguments and to check the results by personal experience and scientific familiarity with the circumstances. The impropriety of direct public appeal by doctors consists in the real risk to public safety. Those who vaunt their own merits, while gaining prestige at the expense of their fellows (and breaking the Gospel rule) are impeding the cause of medicine, and that is the thing that matters. In every question of medical ethics it is necessary to bear in mind the public weal, and also the privileges of a calling whose followers are united to promote that public weal by the advancement of scientific knowledge. Any action which does not depend upon a right view of either aspect of the question will require justification for which the absence of a detailed code of rules cannot be quoted satisfactorily.

THE GENERAL PRACTITIONER'S NEEDS

For the most part the volume deals with the conduct of general practice. Those who hold commissions in the Services or appointments under the State do not experience the same embarrassment either at the commencement of their careers or in subsequent professional positions and ranks, for the conditions of their medical life are already settled for them when they enter upon it.

A Memorandum from the Registrar of the General Medical Council which sets out the powers and responsibilities of that body will make clear the discipline of the profession. The Memorandum is followed by notes upon certain actions which are particularly reprobated by the Council as coming from registered practitioners. Chapters discuss how a practice should be started, how the terms of purchase or terms of partnership should be settled, the position of medical assistants and locum tenents, the working of a panel practice, and the methods for transferring a practice. The keeping of books and filling-up of income-tax forms are further matters on which the practitioner may often desire advice.

It is the general practitioner who most often needs information on his statutory obligations as a registered medical man, on his legal obligations to patients, and on his responsibilities in signing numerous certificates. He is more frequently than the consultant the witness in the coroner's court, where he is often placed in very embarrassing situations, while he may at any time be called in to give medical evidence in other courts. He is more frequently the victim of libel and slander than the consultant, while actions for damages are more likely to be brought against him than against those who by their special position are recognized by the public, as well as by their medical colleagues, as having expert knowledge. But, on the other hand, actions against consultants are attended usually by heavier risks in the matter of damages, and the necessity for joining one of the Defence Associations is urgent upon all engaged in medical practice.

CHAPTER II

SOME CONSIDERATIONS OF MEDICAL EDUCATION

The Preliminary Examinations—The Professional Examinations an Intricate Subject—The Medical Curriculum Post-Graduate Study—The Examination Schemes

IN considering the conduct of practice as a whole there is room for some reflection upon the medical curriculum, in view of the growing appreciation that what was learned in undergraduate periods should be regularly reinforced by post-graduate study. Actual practice is itself the finest form of post-graduate study, but no one practice, though of the most general sort, can range within a limited time over the whole field of our science, while no man can say in what direction he may find it to be of great service to be familiar with later work.

It is a common complaint that the curriculum bears insufficient relation to the problems of practice. The difficulty of applying scientific principles in domiciliary medicine, and the realization of how much that is met with in practice appears to fall into no definite disease group, lead to dissatisfaction, it is often stated that instruction in the management of men and women, and in business methods, might replace with advantage some of the academic training. At the medical schools time might well be found, despite the many claims upon it, for imparting to students the lessons of social experience, but the silence in educational schedules concerning formal teaching on these lines must not obscure the fact that the curriculum is well planned for its main purpose.

A medical man has such a choice of varying careers that it seems well-nigh impossible that any course of training could be equally adapted to all of them. The professional curriculum

has to be devised so as to train, in the public interest, the general practitioners—who are themselves subdivided for practical purposes into various categories mainly dependent on environment—and the consultants of general or special character. It has to form a fitting equipment for the official medical man, whose time will be occupied with discharging duties of a sanitary, educational or institutional nature, or who will hold an official appointment in the Colonies or a commission in one of the great Services. This list of the classes into which the medical profession in this country falls is more fully analysed in the next chapter, it shows at once that it will be extraordinary if differences of opinion do not arise with regard to any educational curriculum more or less designed to be suitable to all. As far as the conduct of practice is concerned the essential need of an educational scheme is that it should so inform the student that he can undertake, with safety to the public, the ordinary responsibilities of a medical man, can profit by the clinical experience of practice, and can proceed with intelligence to any branch of his science for which he feels a special adaptation.

THE PRELIMINARY EXAMINATIONS

At the beginning there is the difficulty of deciding the point up to which general education must be common to all classes of students, and where some account should be taken of the intention of any to devote themselves to one or other particular profession. Everybody allows that in a profession like medicine, as it has become to-day, it is necessary that all the students should have a general education up to a fairly high standard, otherwise the scientific foundations will be difficult to lay later. But as to how high that standard should be there is no agreement. It is no longer quite idle to say that every medical man should go first to a university, for the spread of educational facilities has made this possible for so many, as will be seen by consulting the Students' Numbers of the *Lancet*. There are men whose cast of mind is such that the university exactly suits them, and it seems likely that but few of these

in the future will be unable to get a university training. But there are others who might not be helped in this way to develop in a useful manner, their powers of initiative and originality of impulse will enable them to come to the front on a less rigid equipment. The ideal general education for medicine must be sufficiently high in standard to give its possessor the power of grasping professional subjects, and yet not so high that unnecessary time and labour have to be spent by the unreceptive in the acquisition of knowledge that is not germane to the conduct of practice. As a matter of fact, all knowledge must be useful to a man who has to live in intimate association with all sorts and conditions of men in all sorts and conditions of circumstances, so that those who are opposed to the university standard can put no upward limit to what should be suggested in its place. The grade of early education which suits the bent of the largest number of students would seem the right one, while no standard can suit everyone, and the General Medical Council is right to leave the matter in the hands of the various statutory bodies granting degrees and diplomas.

THE PROFESSIONAL EXAMINATIONS AN INTRICATE SUBJECT

Medical education is divided into preliminary or ancillary subjects and purely professional subjects, but not with any sharp line. All instruction in the practice of medicine is, of course, a purely professional matter, while instruction in the sciences upon which medicine is directly founded—viz anatomy, physiology, psychology, chemistry and physics generally—is in a sense preliminary. Anatomy and physiology may be regarded, however, if we like, as more directly professional subjects than the others, but chemistry for example, having regard to modern developments of biochemistry, can hardly be held as merely ancillary. With these things in our mind we are prepared to find that the subject of medical education bristles with points for debate. In addition to the necessity that the general education of the medical student should be conducted to a point which is not

agreed upon, and in addition to the fact that the subjects germane to medical education are not settled beyond dispute, we may have to consider what amount of specialization is necessary in a curriculum which must be designed to fit young men for very varying careers

One extremist may say that everybody should have a university degree before he begins professional work, another may be found saying that everybody should have a degree or diploma before he attempts to specialize, and that such subjects as public health and hygiene, the use of medical statistics, and the technique of pathological research should all be acquired as post-graduate subjects, the curriculum being merely designed to bring all students up to a standard whence they can safely diverge along special paths

In many debates on the curriculum which have taken place in the General Medical Council, with a view to make the educational course of the student practical as well as sufficient for the public needs, the question of the time to be allotted to the different subjects has been a turning point, and any recommendations that have followed have pointed to developments at each end of the curriculum which have since, in great measure, taken place. The preliminary scientific education can now, to some extent, be secured at many big and approved secondary schools, while it is generally admitted that certain special subjects may be left to a large degree for post-graduate instruction. But no medical man is specially equipped for his public responsibilities—and the curricula at various education centres all recognize this—if he is not able to deal with emergencies arising in connexion with special practice. He need not be an ophthalmic surgeon or an otological expert, but he must be able to recognize the main conditions so that he may ask with intelligence for special assistance. In the same way he is not expected to be an expert upon hygiene or upon lunacy, but he must be able to detect where he has to deal with questions of general infections, or with early mental symptoms, so that he may cooperate promptly and usefully with his colleagues,

the medical officer of health and the alienist. Post-graduate education will be entered upon according as the need is felt to fill gaps in one direction or another, while the taking out of the appropriate diploma will be practically a necessity for those who wish to specialize.

THE MEDICAL CURRICULUM POST-GRADUATE STUDY

In the conduct of general practice post-graduate education will soon become an integral part, the habit of taking study leave is growing and opportunities are being made by many men for these intervals, while post-graduate classes are recognized now as a necessity for officers in the Services. In private practice the need for post-graduate training differs somewhat from that experienced by the officer, and often the benefit obtained by attending post-graduate classes would be more substantial and permanent if the practitioner, before taking his study leave, were to glance back at his original equipment and ascertain the principal weaknesses in its fundamentals. The man with special duties knows exactly what work he requires to add to his knowledge, or what territory in his duties requires re-surveying, but the general practitioner may feel the want of assistance in a much less specified manner, and it would often be remunerative if he would himself test the foundations on which the new superstructures are to arise.

It is too much assumed that the knowledge acquired in years gone by, for the satisfaction of standardized tests, remains for application in practice, but the assumption is only a loose one, for no one supposes that the minutiae of anatomy, of chemical formulæ, and of laboratory technique abide in the memory, so that without reference to manual or notebook their place in the conduct of an actual piece of clinical work can be seen at a glance.

But as actual practice is engaged upon, and new personal wisdom is acquired, it is often a revelation to the man who formerly attained to a good level in his training to find that what he had learned as a student, because it was in some

schedule, is forming the basis for what he is doing successfully in his day's work. In reviewing that work he will be led to see that this useful and pleasant association with his original training does not prevail all along the line, and it is the gaps that he should seek to fill.

The ideal medical curriculum has been held to be one in accordance with which a man learns all that will be demanded from him by the public, as a representative of the medicine of his date, he should not be burdened by the compulsory acquirement of what he will not be able to make use of. It need hardly be said that educational authorities would never agree upon how exactly such a curriculum should be framed. Some would desire many inclusions and others many exclusions from any scheme submitted to them, as the debates in the General Medical Council have shown over and over again. No one can assert that we enjoy at the present, either through the wisdom of the particular educational centres, or through the average of their aggregated efforts, or through the organization of the General Medical Council, a professional curriculum that is neither wasteful of time by the inclusion of redundancies nor oversparing of time by the sacrifice of attention to important things. But what concerns the conduct of practice to-day is how to use the sound medical curriculum which we possess—and there is international testimony to its soundness—for the greatest advantage of the public and the doctor. It is a good policy for the practitioner to consider what he learned under that scheme in connexion with his immediate work, so that, in determining to keep himself abreast of contemporary knowledge, he may make definite plans for post-graduate study. It is obvious that a revision of chemistry or of mathematics, and even a little study of weights and measures before considering calories and food values, would often render attendance at post-graduate classes more fruitful of good. While deciding in what direction he wishes to extend his particular knowledge the practitioner will be well advised to strengthen the foundations of his knowledge at any weak spots.

THE EXAMINATION SCHEMES OF THE UNIVERSITIES AND
EXAMINING BOARDS

We have been often told of recent years that the introduction of the university pattern into the education of medical students would produce certain great things, but the various courses of study as standardized by the General Medical Council are on much the same pattern, whether the education is preparatory to a university degree or to a diploma. A matriculation or entrance examination is required, which is usually harder at the universities, and at one time was particularly hard at the University of London, testing in the ancillary subjects follows by differently named examinations and with variations in the arrangement of subjects, and lastly come the examinations in medicine, surgery and midwifery proper. The objection that the education of the medical student is conducted too much in water-tight compartments, so that the relations of chemistry and physiology, physics and anatomy, to medicine and surgery are not kept before the student's mind has real force, but attempts are now being made to meet it. The reason why this position has not been much admitted by the authorities—at any rate until recently—in the case of the student, disappears in the case of the man in practice. He has acquired a personal knowledge of the eventualities of medicine and surgery, but he may often find that, if he desires to extend his knowledge, he will save time and gain clearness of perception if he tests, and where necessary revises, his early academic training. This, of course, is more immediately obvious where the practitioner elects to seek post-graduate training along some special branch of practice, he is almost sure to find that the developments of that branch which he wishes to make use of imply the understanding of, or familiarity with, preliminary subjects which he no longer possesses.

Addition to knowledge can be obtained by the regular consultation of contemporary literature, as well as through post-graduate classes, but a preliminary revision of fundamentals is essential if the maximum benefit is to be gained.

CHAPTER III

THE CHOICE OF A CAREER

*Recent Changes in the Medical Life—Entry into Practice
Deliberation Necessary*

THE medical life is a full and fine one; calling for the exercise of high practical as well as scientific qualities, and affording opportunities for the exercise of these qualities in many forms. A survey of the medical profession at once reveals the varied opportunities that the medical life holds out to men of different bents of mind. The general practitioner, the consulting physician, the operating surgeon, the holder of purely scientific appointments, the officer in Government and municipal employ, the medical manager of institutions, the medical officer in the Services, lead careers which differ entirely, though the reason for their working lives—the prevention and remedy of disease—is common to all. For some life will be essentially adventurous, for others it will be spent in two or three wards, an operating theatre, and a consulting-room. Some will be the trusted friends of the great, many exclusive social doors will be open to them, and intercourse with intellectual leaders of all sorts will be their right, others will serve under authorities and municipalities composed of men whose education and position may not be equal to their own, even while the wide extension of public culture is allowed for, and some will live in daily and intimate intercourse with the poor. The man who loves the study of his fellows has social and psychological problems unrolled before him from hour to hour—he sees naked souls as well as naked bodies, and has to take the treatment of both into his consideration. No special application of psychological knowledge by experts, either within or without the profession, can alter the position that the sound doctor

must be to a great extent a sound psychologist, and every general practitioner knows this so well that he seldom alludes to its obviousness. He whose sympathies are rather with the theory than with the practice of his art can exert his energies in the classroom or laboratory without coming into collision with the public. The sportsman can indulge his proclivities in moderation whilst discharging his professional duties with zeal, though small will be his chances of success if the zeal is manifested too much over the sport and the moderation is applied to his appetite for his duties. All sorts of persons in all sorts of methods and under all sorts of skies can carry on the profession of medicine, so that there need not be many to whom the medical life is irksome, though there must be few for whom it is not arduous.

There will be an unfortunate minority, who, being by nature designed for work of one kind, have by stress of circumstances been forced into a different groove. Probably they did not discover their own tastes until it was too late to work in the necessary direction, and this error is a very difficult one to rectify, whatever calling a man may adopt. But it can be avoided in many cases by the resolve of the student not to be too precipitate in making up his mind as to what exact future, inside the medical fold, he is best fitted for. Speaking generally, the profession of medicine has this first advantage for its British disciples—an advantage which citizens of other nations do not enjoy—it offers a career that can be varied to suit all inclinations. Further, a high percentage of the followers of medicine attain to a fair degree of success, and the total failures are comparatively infrequent. These things must always be remembered, for, while certain circumstances may be held to detract from the medical life—the tyranny of many of its conditions, for example, and the strain of many of its conjunctures—they establish it as a good life, for it offers chances to a man with brains and energies, a large choice in the sphere of labour, and to a fitting extent an opening for individuality.

RECENT CHANGES IN THE MEDICAL LIFE

That the medical life, despite its common objective remaining the same, will be changing perpetually is proved by the development of clinical medicine, which has been so striking a feature throughout the last fifty years. There has come for the doctor of to-day numerous alternatives in professional life which did not exist for his immediate forerunners. The student of fifty years ago had to regard his studies as leading up to one of three or four methods of making a livelihood. Pathology was synonymous with morbid anatomy, and of those scientific developments in medicine which are the pride of our time the foundations were only being laid, largely by medical men in the intervals of practice. There were no bacteriologists and the whole of the biochemist's story remained to be told. But the vitality of medicine is illustrated excellently by the fact that, as the separate branches of the medical life have become more differentiated, intensive study along the various lines continues to reveal gaps in our knowledge previously undetected, affording boundless opportunities for research. Everyone, for example, who tries to keep abreast with the literature of our calling will have noted the increasing authority with which it is possible to speak on the manifold problems of nutrition, and will also have noted the many places where theories require confirmation and statements ask for support, both of which will have to come from the men and women who are doing the clinical work. The general practitioner has greater opportunities to carry on investigations bearing directly on the treatment of disease than the laboratory worker, and the insistence which has been laid always in British schools upon the importance of clinical training fits our practitioners, while discharging the duties of practice, to collect and collate those clinical facts upon which science depends in its forward march.

From the list enumerated of the varying lives which the members of the medical profession follow, it is obvious that certain practitioners have little choice with regard to

many of the essential matters in the conduct of practice. In subsequent pages the regulations under which the officers in the Government Services carry on their work will be found summarized, and medical practitioners in these Services are sheltered largely from the difficulties whose discussion will be forming the main subject of these chapters. Those engaged in public health work or institutional duties are betrayed only through exceptional circumstances into actions which can be regarded as of an unprofessional nature, whether in relation to the public, the patient, or their colleagues. For all practitioners the duty of the observance of the general principles of professional conduct is an absolute one, and there will be no point in indicating how this duty bears particularly upon the consultant, the specialist, or the official in any other way than upon the general medical practitioner. But it is clearly the last who has reason most frequently to consider what course he should pursue.

Two generations ago the student engaged upon medical studies with the usual intention of entering upon some particular career which had its academic or practical attractions for him. He intended either to become attached, if he could compass it, to his own or to some other hospital with a medical school, and join the consultant branch, or enter one of the public Services, Government or other, or engage in private practice. In London and the greater capital towns of the country the medical staffs of the hospitals constituted the corps of consulting practice, and they had the education of the students in their hands. Entry to this corps was guarded, and in the metropolis strictly guarded, by the necessity to obtain certain degrees and diplomas, while the facilities for securing these were not provided in any orderly manner by the educational curricula of the schools. The posts of the special hospitals were largely held by men who were already, or who hoped to be, elected to the general hospitals, and where a new special hospital was instituted by private endeavour, with the view of being purely special, the leading members of

the movement in some instances had to run the risk of being suspected of a desire to appeal with too great directness to publicity for their personal practices. In the provinces the elections to the staffs of the hospitals were made from the prominent local practitioners, who were often in general practice and sometimes partners in firms of general practitioners. The possession of honour qualifications was here becoming frequent, but it was not as a rule made a necessary condition for election. In the larger cities the staffs of the great hospitals became, as a rule, the recognized leaders in their own medical world, and frequently gained the same position outside the local centre. As these centres became the sites of universities the medical staff formed the medical faculty of the university, for the institution of which the faculty itself had often been a prime reason.

While the medical consultants and teachers became thus comparable to their colleagues upon the staffs of the historic teaching hospitals, and as exact scientific knowledge increased, two things occurred. First, in addition to special hospitals, special departments were added to the large general institutions, and, secondly, the teaching of the preliminary subjects in the schools was found to require the assistance of experts. In this way there has resulted a vast increase of opportunities for consulting and special work, including teaching. These openings have been further enlarged by the development of pathology, the institution and multiplication of laboratories, and the liaisons with other sciences. Although the medical man who resolves to play his cooperative part in the work of healing along the lines of scientific rather than clinical research must recognize that he is foregoing many material advantages that might possibly have accrued, there is at last a real impetus to the endowment of scientific posts ancillary to medicine. Further, the institution in London of university clinics, while it is developing research work in connexion with the clinical courses, has led to the creation of salaried posts open to the class from whose systematic work have come the teachings of modern medicine.

The developments in our knowledge of hygiene have led to the organization of the health service, whose members enjoy in the higher posts whole-time appointments, and fairly successful attempts have been made to obtain proper salaries and conditions for these officers, their whole-time assistants, and the heads of tuberculosis and educational departments

ENTRY INTO PRACTICE DELIBERATION NECESSARY

Now all this wide field of scientific and clinical work would appear at first sight to display so many inducements to turn away from general practice that we might expect a shortage to occur in the general ranks. But if the facts are rightly appreciated nothing of the sort should occur, though for comprehension of the situation thinking is required from every practitioner before he makes a professional start. He should try to decide what his preference is, and for what life he is best equipped. The more numerous approaches to consulting practice should not influence him unduly, for many who are thus attracted regret a too early decision. He should ascertain the circumstances of a medical career in the Fighting Services or the Colonial Medical Services by consideration of the Regulations which are published yearly in the Students' Number of the *Lancet*, and from the same source he can obtain full information on the conditions of a career devoted to sanitary, educational, or psychiatric work. And if he decides in favour of general practice, he may be assured that general practice is still the best field of activity for three-quarters or so of the practitioners on the Register. For the public medical services do not encroach nearly so much as has been believed upon general practice. Panel practice affords an opening for, it is estimated, 15,000 practitioners, attending upon 14,000,000 or 15,000,000 patients, and there is no limit put upon the private endeavour of those who ensue it. Further, in the Services themselves there will be found very many general practitioners. In the sanitary service, for example, little more than a quarter of the officers have full-

time appointments, the remaining 1,000 posts, or more, being filled by general practitioners. It has been pointed out recently by Sir George Newman, Principal Medical Officer to the Ministry of Health and Board of Education, that a further 1,000 general practitioners are engaged by local education authorities in the inspection and treatment of children of school age, while nearly all the "appointed doctors" under the Factory Acts, like their precursors the "certifying factory surgeons," will be in private practice.

The intending practitioner, in the later stages of studentship, should try to arrive at what he wants to do and to gauge his fitness for doing it, while he might well consider what particular opportunities he possesses for following his choice.

PART II

ENTRY INTO PRACTICE

CHAPTER IV

SOME CONSIDERATIONS OF GENERAL PRACTICE

The Advantages of a Temporary Post—Town and Country Practice—Panel Practice—The Advantages of Partnership—Individual Practice

A CAREER upon which some three-quarters of the medical profession embark must itself have many sides. Whereas other practitioners have their main circumstances allotted to them by the nature of their duties, and by the emergencies which they will have to meet in direct connexion with the scope of those duties, the circumstances of the general practitioner are dictated to a greater or less degree by the whole conditions of society.

Some of these conditions may be common to all general practice, but others will affect only certain divisions. General practice in the metropolis or the large capital towns will differ in routine and opportunity from general practice in smaller centres, where there are less chances for cooperation if less competition, and such a career, again, differs from that led by the unopposed country practitioner. Increased facilities of transport have certainly removed for the latter practitioner much of the deadly isolation of his life, at the same time, the resourcefulness and the nerve which are demanded of those who can establish contact only after delay and difficulty with professional assistance too often go forgotten.

The young doctor who has spent a year or more holding house appointments in his own hospital, whether in London or elsewhere, need not be afraid that he will find himself incapable of dealing with the purely medical side of general

practice Indeed, there may be a freshness about his knowledge and a precision about his clinical methods which he is only too likely to lose as years go on, and the best resolution that he can make at the beginning of his career is never to let the gaps in his knowledge grow wider or his clinical investigations become slovenly in the crowded hours of a strenuous life

When the choice for general practice is made, the beginner's first steps will depend to some extent upon his age If he has become qualified while still young, he can be confidently advised, even if he has already held house appointments in the hospital associated with his own medical school, to seek the post of house officer in a provincial town situated in the part of the country that has attractions for him If, however, he is already rather above the average age when he takes his degree or diploma, he will have to decide between the two, and apply for some appointment either in his own hospital or in the provinces—he cannot usually afford the time to do both In this case there are for the future general practitioner advantages accruing from choosing the provincial appointment. They are these first, he is likely to find that he has more opportunities for professional initiative than he would have had in his teaching hospital, secondly, as the hospital staff is almost certain to include men who have been trained at several different centres of medical education, he will have a better opportunity of comparing different methods of treatment than in the hospital attached to his school, where almost the whole staff would probably still be working in the same institution in which they had spent their undergraduate days themselves, and, thirdly, the appointment may prove to be a stepping-stone to a satisfactory opening in general practice The provincial house surgeon is necessarily brought into contact with a number of practitioners, and it sometimes happens that through the acquaintanceships so formed, he may at the conclusion of his appointment find one of them glad to welcome him as an assistant, with a view to a partnership later on

THE ADVANTAGES OF A TEMPORARY POST

But such a contingency cannot be counted upon, and on the completion of his hospital appointment the beginner will be well advised to take his first step in general practice by working for a few months as *locum tenens*—both in order to learn the special difficulties of general practice, where the mistakes that can be made simply through inexperience are so many, and also to discover what kind of work is likely to be the most congenial to him. It has been suggested that the full value of these temporary posts is only gained by those who hold a series, a procedure which on some grounds cannot be advocated.

In these temporary posts the beginner should be making his choice deliberately between work in town and in the country, and he must be careful not to allow the experience gained in a few weeks to prejudice him too strongly in favour of a country practice. The real test of the strength of a man's taste for country practice can only be made in the winter. An engagement undertaken, perhaps, to give a friend the opportunity for a summer holiday is likely to give far too favourable an impression of professional life in the country. Indeed, the first few weeks' introduction to almost any practice is apt to be followed by a period of disillusionment. The excitement at finding how full of educative medical material is the neighbourhood may not remain. While every patient is new, and while many of them are instructive from a purely professional point of view, all is satisfactory, but the work must lose the attraction that novelty gave it. The interesting cases will become familiar, and those new cases which present any striking feature will appear few and far between. Then the young doctor must fight against disappointment. The original impression may turn out to be correct after all, but the beginner must prepare himself to face a certain feeling of depression after his first few weeks in general practice, and certainly he should not make a permanent choice in favour of a country practice, basing his decision

on a month's work undertaken in some pleasant district in the summer-time

TOWN AND COUNTRY PRACTICE

What type of man can be advised to choose country practice for his career? The choice is momentous, because the most important asset in a medical man's practice, especially in a country district, is the duration of his residence in the neighbourhood. So before deciding to become a country doctor, a man should consider not only if the life is likely to suit him while he is young, but also if he can settle down in it contentedly for a prolonged career.

One reputed drawback to assuming the duties of a country practitioner should not affect the decision. Many young men have been told that a country practice is excessively fatiguing and only suitable for men of particularly robust physique. This is a tradition handed down from the time before motor vehicles had been introduced—to confer greater benefits upon country doctors than upon any other class in the community. Their general use by doctors, however, is comparatively recent, and it is natural that the accurate reflections upon the previous conditions of medical life in the country should retain some influence now that the conditions have changed. The introduction of trained midwives into many villages has been another factor of hardly less importance in lightening the burden of country practice. There can be no doubt that, in the country, midwifery is the most fatiguing part of the day's work, even now that many normal cases are cared for by the certified midwife. The result of these two changes taken together has been radical. The old advice on the value of exceptional physique was itself exaggerated, but to-day no one need be deterred from country practice who is robust enough for general practice at all. In fact, anyone who, not being very strong, hesitates between town and country work, can be advised to select the latter on many counts. The man who can be especially recommended to choose country practice for his career is one who is fond of the

country-side in the winter-time—that is a real touchstone. And he must love his profession as a whole, without being attached to one branch more than to another. For in the country he will have to become the handy man of the profession and to take an equal interest in every case that presents itself.

The financial prospects are never brilliant, and the doctor may have to work hard for a small income. On the other hand, he is likely to find that poverty is less vexatious in the country and that, however poor he may be, he will probably be at least as well off as most of his neighbours. Geographical facts may set a definite limit to the possible growth of his practice, and exceptional ability will therefore never have as great a reward as it might obtain in a town. On the other hand, country patients are conservative, and the position of a country doctor becomes steadily more secure year by year.

The prospects of a country practice from the scientific point of view will be to a large extent a matter of using the material aright. Deprived of many of the facilities which he enjoyed at a hospital, and could still have enjoyed to some extent if he had decided to practise in a town, living in some degree of isolation and far away from any teaching hospital, the doctor's experience will be confined to that to be gained from the treatment of a small or scattered population. He has continually to be on his guard against the danger of losing his professional enthusiasm, but for some this very insularity will have its advantages. He will feel the need to be continually learning, and may think out independently the answers to many therapeutical problems. His professional knowledge, as it grows adequate, will assuredly grow wide, and he will have constant incentives to widen it as the necessity obtrudes itself, the specialist working in a comparatively narrow sphere may be led to think that he knows enough, but a good country doctor will be free from this fatal temptation. Moreover, living as a member of a small community, he will be in closer contact with his patients, and become more intimately

acquainted with their illnesses, their modes of life, and their family relationships, than would have been possible in an urban practice. He should be able to turn this knowledge to professional uses, and become, as years go on, more accurately conversant with the natural history of disease than many doctors whose horizon seems to be a wider one.

All this can be said for work in the country, let us look at the prospects of an urban practice. The successful general practitioner in a town of moderate size holds a position which, from the variety of professional experience and the financial reward that it brings, is likely not only to be far superior to that of the country doctor, but at least as desirable, pecuniarily speaking, as that of many consultants. In the country there are definite limits to the expansion of a practice, which in a town is always possible. A good urban practice may grow up from a very little one, especially if the particular town is increasing in population—and wherever the young practitioner thinks of settling, and whatever the existing inducements to settle may be, one of the points to which he should direct his attention should be the probable future of the place. In the country, patients as a rule are very conservative, and unless a new-comer has some unusual advantages in his favour he is not likely to increase the size of his practice very quickly, of course, on the other hand, if he has the capital to purchase a share in a good country practice, he is very unlikely to lose his money. But in the town a young man may be able to purchase the nucleus of a practice and develop it very rapidly. So there is no doubt that for the impecunious beginner town life holds out better prospects. Besides, it has many other advantages. The young doctor, if he starts work in a fair-sized town, will have opportunities for keeping himself up to date which would have been far to seek in the country. He will be able to see more of other medical men and attend meetings of medical societies, he will more easily obtain the services of consultants, and will very likely be able to keep in touch with the work of the local hospitals. If he looks further

into the future he will not fail to see the advantage he will have over a country doctor in the matter of educating a family, though, on the other hand, if children could have the choice, they would vote for country life

A VIEW OF PANEL PRACTICE

On the subject of panel practice we go over familiar ground, but the conclusions are those that have been reached by the majority of practitioners. Many far-seeing authorities agree in believing that through the perfecting of the existing organization we may achieve a medical service in which practitioners of all classes and institutions of every design and scope, having the health of the people as their objective, will find an active part to play. And all this without the defects inherent in a State service as usually devised.

The country practitioner will almost inevitably have to join the panel. In a town he can join it or not, according to the circumstances of his practice. The beginner is likely still to hear much unfavourable criticism of the panel system, but he can be assured that if a census were taken of those medical men who have experienced its working, the majority would vote for its continuance—with reforms. The reasons are obvious. To a working man the expense entailed by a serious illness is a financial disaster comparable to the loss which a professional man would suffer if his house was burned down. In both cases insurance is the only reasonable safeguard, and in the first case a national and compulsory system of insurance has obvious advantages over a voluntary one, both on the score of economy and efficiency alike. At present the system is only in its infancy and is not free from faults, but that it is already of great benefit to the working-classes is apparent to anyone who spends much of his time with them. And if it is of benefit to them, so, too, is it beneficial to their medical attendants. If merely the financial side of the question is considered, we perceive that as the working-man is spared the anxiety of receiving a medical bill which he cannot afford

to pay, so is his doctor spared the embarrassment of sending it out and the uncertainty of the result. And at any rate for this financial reason, if for no other—the fact that the money comes in regularly and that there are no bad debts—the Insurance Act has proved itself a boon to the general practitioner. There are reasons for thinking the scale of payment which the panel doctor receives is too low, but the money is paid regularly and can safely be counted upon.

Moreover, there are other points to consider in connexion with the Insurance Act. It should be looked upon as only a part of a large and as yet imperfectly coordinated movement, of which the end will be attained when all members of the community enjoy equal privileges as far as the prevention and treatment of their physical ailments are concerned. The movement includes most of the political measures which are the common topics of conversation—such as town planning, improved housing, provision of playing fields, smoke abatement, and similar matters. The National Insurance Act, as its gaps are filled up and the most is made of its good points, will soon have a striking effect in improving the health of the population. It is only recently that many Approved Societies have begun to provide money for dental treatment, and already the doctor has seen how eagerly this help has been welcomed, and how beneficial it has been. To-day no one could be found bold enough to argue that what is beneficial to the health of the community is not necessarily to the benefit of the medical profession, and whatever its demerits, the principle of insurance has substantial advantages for the doctor. So, far from being deterred from country practice by the fact that the country doctor is almost necessarily a panel doctor, there are some grounds for thinking that it is in the country that the Act works best and is of most benefit to the patients and medical profession alike.

THE ADVANTAGES OF PARTNERSHIP

The three possibilities before the commencing general practitioner are (1) to start an independent practice, (2) to

purchase a single-handed practice, and (3) to purchase a partnership, either (*a*) by prefacing such a purchase by acting as assistant to the seniors, or (*b*) by buying a partnership in an established firm. Personal predilection and personal opportunity will decide the young practitioner upon the course to be taken. All purchase early in a medical career will be regulated by the money at command, and there will be many circumstances which will lead a self-reliant man to embark upon individual effort. In urban practice this does not imply the isolation that it does in a rural district, while in the latter it is easy to see that in a desired locality the available practice might be a single-handed one. In each case the position of the beginner is different to-day from what it was before the National Insurance Act, as a certain number of panel patients may be anticipated, but undoubtedly the advantages of obtaining a partnership, where possible, are appealing in an increasing manner to young doctors.

The beginner may confidently be advised to enter the largest partnership he can find, for, whether in town or country, the advantages of such a partnership are solid. One partner can act as locum tenens for another, with the result that each can take a holiday in rotation and—which is of special advantage in the country—can avail himself of annual post-graduate courses. In a large partnership it should be possible to admit a new-comer on easier financial terms, while the very size of a partnership is evidence of its financial stability. On the dissolution of a partnership of two the remaining partner may not be in a position or may not desire to purchase the other share, while in a large firm the arrangements for allowing a junior to buy himself in slowly become more feasible. Lastly, each partner in a firm will be bringing some particular contribution of skill and experience to the conduct of practice, so that the beginner will be likely to have a promising field for the development of any special interests he may have in one or other branch of the profession.

There will be found in the chapter dealing with medical

partnerships (see Chap VII) an analysis of the nature of the contracts which should be entered upon, the necessary definitions that should be made in partnership agreements, and notes upon the division of work among medical partners with special reference to the juniors of a firm. Whether a beginner has any capital or no, he will be well advised to begin as an assistant with a view to partnership later on, but, of 'course, if he has no capital, it is no use his taking such a post unless the salary is large enough for him to save a fairly substantial sum each year, otherwise he will be making no progress towards the purchase of his share. He will naturally make up his mind to live at first with the utmost economy, and should be able to see his way clear to the saving of at least £150 a year, before he takes a position as assistant. It is not so much the size of the salary, as the amount of it which he can save, which is important.

It should be stipulated that if, at the end of a certain period, his principal is unwilling to admit him to partnership, the younger man should receive some pecuniary compensation. A fair amount would be the difference between rather a small and rather a large salary for one year. Because, of course, if the younger man has put in a year's work, with a view to a partnership which has turned out not to be forthcoming, he has suffered a definite disadvantage, unless he receives a sum of money to make up for the time that he has lost so far as getting established in a practice is concerned. The beginner will naturally expect to have definitely stated in his agreement with his future partner the date on which he will be entitled to purchase his full share of the practice. In some agreements the new-comer is kept waiting far too long, and nothing is more likely to lead to friction between two men, than if one of them finds himself for a long period doing perhaps more than his share of the work, and receiving considerably less than his share of the income. So, unless a prospective partnership offers a new-comer the chance of obtaining his full share in at any rate five

years' time from the date that he starts work as an assistant, and unless he can see a reasonable chance of saving or borrowing the requisite sum in that length of time, then he would be well advised to go elsewhere. For a young man must remember that it is only in his first few years in private practice that he will be able to live very cheaply. For most men time brings continually increasing expenses, and an income that was ample at twenty-five and thirty, may easily be insufficient ten years later. Financial generosity is the cardinal virtue of an older man in dealing with a new-comer, and is one that will be remembered with gratitude for all the years that a partnership lasts.

The possibility of renting a satisfactory house must be kept in view. Nowadays it is often easier to buy one than to rent one, but the young doctor will naturally wish to use any capital that he has in the purchase of his share in the partnership. Of course, while he is an assistant, he may be able to lodge economically enough, but on entering the partnership, he will have to provide himself with a suitable house, and he will be wise to consider what his chances are in this respect before he settles down in any neighbourhood.

The new-comer must try to work harmoniously with his seniors, for unless two partners work together on terms of personal friendship there is very likely to be a friction sooner or later, which would counterbalance all the advantages that a partnership brings with it. The younger man can do much to make a partnership a success by showing a readiness to do most of the night work and of the more disagreeable side of the day's business. He should regard the older man's opinion as more valuable than his own, and remember that experience is worth a good deal of the fine polish that knowledge may have lost in gaining it. A little deference is the right of an older man, and should be shown him on appropriate occasions, tactless patients are often responsible for friction between partners, which may be avoided by mutual good-humour. In an assistantship, or while working as a junior, the experience of the older

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man will range over many points in general practice that can best be learned in this way

Before the beginner decides to enter a partnership, he will be wise to gain experience in the business side of a practice, and to devote his attention particularly to such things as the ordering and dispensing of drugs, the fixing of fees and the sending out of accounts, and the general management of patients whose attitude towards their doctors is 'difficult'. He should also gradually gather together the equipment which he will need later, bearing in mind that the requirements of practices differ in respect of what will be necessary, and that only those instruments should be bought of which the need is certain and the use familiar. He will be well advised thereafter to set aside an annual sum of money for the purpose of gradually making his equipment more complete.

INDIVIDUAL PRACTICE

The precepts which follow are applicable to those who, early in their career, either purchase a practice or "put up a plate," hoping that patients will come their way.

If the new doctor sees but few patients at first, he will be hard put to it to remember everything about them, so he should begin at once to make a careful system of notes about all those that he sees.

Secondly, he will find that the arrival of a new doctor, especially in a small place, is apt to cause a certain excitement among patients of a particular kind, and he may very likely be agreeably surprised to find how many consult him during the first few weeks. Unfortunately for him many of these will be patients who either for financial or other reasons are continually fitting from one doctor to another, and most of them will very soon desert him.

Thirdly, he will meet with continual difficulties in carrying out the rules of treatment which he has formed in hospital practice. He will very likely have made up his mind that in every case of appendicitis, in which the diagnosis is evident, the right treatment is immediate operation.

Now in private practice he is likely to find a higher proportion of mild cases than he saw during his training in hospital, and if he advises immediate operation in every case, he will meet with much opposition from patients and their friends, and some of it will be reasonable. Here he must insist upon consultation, and must remember that a patient usually comes to hospital in such circumstances quite prepared for an operation, while this is not so in private practice. If the attack is a mild one, the idea of an operation may be startling to the patient and to relatives. But there is no doubt at all that, even from the point of the success of his practice alone, the beginner will find it wise to stick to his guns, and rather than break a good rule, let the patient betake himself to other advice if consultation is refused. Eventually he will find that his advice, which at first was lightly regarded, will receive more respect, and as in many other matters, difficulties tend to grow less formidable as the years go on.

Most men, on beginning private practice, are struck with the great difficulty of accurate diagnosis in many cases. The reason is sometimes that they are seeing patients who are suffering from inconveniences that are relatively trivial, though not on that account by any means the more easy to fathom. And some of the patients are being seen at an earlier stage of serious illness than are those who come for hospital treatment, and here is the splendid chance for the general practitioner. He has to face the difficulty that most of his patients will expect a conclusive diagnosis, and it is fortunate that, in the honest attempt to give this, an exhaustive examination must often be made, proving to the patient the interest taken in his case. Carefulness in examination is the greatest asset a man can have, while where an accurate diagnosis is found impossible, information of value can always be given. For instance, the patient with fears of cancer, which he has not mentioned, will be wonderfully benefited if he can be assured that the fears are groundless. Nowadays the fear of cancer is so widespread that in dealing with middle-aged patients, at

any rate, we should never forget the possibility of this obsession being at the bottom of their minds. Even in cases in which doubt remains it is often better to discuss the matter with such patients, so that they can see their position and learn the medical response, for, while all worries are the better for being discussed, such patients can be sent away with a more reasonable attitude to their complaints than a vague and ignorant dread of impending calamity.

It is well to remember that, while in hospital training the main emphasis is laid on accurate diagnosis, in general practice, although this is still the most important and difficult part of the work, it is treatment which the average patient comes seeking. And it is by his skill in treatment that the young doctor will be judged. In the hospital skilled nursing will render a good deal of the treatment which in private practice must be done by the general practitioner. There can be no better rule for the beginner than this: "When in doubt do the treatment yourself, and look out for opportunities of carrying out simple treatment." In a working-class practice the most important part of the work may be to see that the more serious cases are properly nursed. The doctor will have to teach the elements of nursing to unskilled relatives over and over again, he will have to overcome their prejudices, and to succeed in doing so, he will have to begin by understanding them. But the beginner may comfort himself with the reflection that most of the difficulties which he will meet with at the opening of his career grow less formidable as his experience broadens.

CHAPTER V

THE MEDICAL LOCUM TENENS

Mutual Coöperative Schemes—Agencies and Fees—Restrictive Covenants—Questions of Obligation

THE medical practitioner who acts temporarily as a substitute for another medical practitioner is technically known as a locum tenens or, colloquially, a locum

The position of a locum tenens is often very difficult. The practice into which he suddenly enters may be conducted on lines with which he is entirely unfamiliar. The principal may have had but little opportunity of making the locum acquainted with his methods, or of explaining in detail the various cases for which the locum must now assume responsibility. Not only are the patients complete strangers, but the district and local features may be entirely unknown, and too often the locum has not even the advantage of knowing the principal. It is not surprising in such circumstances that complaints are sometimes heard of the unsatisfactory character of a locum tenens. Difficulties must necessarily occur when an unsuitable locum is placed in charge of a practice, and the principal should therefore take great care in the selection of a substitute.

It may happen that a medical man in practice is asked to see a patient during the absence of a colleague through illness or other cause. Here the practitioner acting as locum must carefully avoid doing or saying anything calculated to prejudice his colleague's interests, and must on no account consent to remain in attendance on the patient when his colleague is once more available. He may reasonably claim to be remunerated for his services, but that should be arranged with his colleague and not with the patient. Frequently no claim is made for payment, more particularly when the service can be reciprocated.

In many areas it is now quite usual for the local practitioners to arrange systematically to deputize for each other whilst on holiday, and so avoid the necessity of importing complete strangers as substitutes for the absentees. The arrangement works well in many cases, when it is highly creditable to those concerned. A very elaborate scheme has been arranged at Leicester in connexion with the Public Medical Service. The benefits of the scheme are limited to those who are prepared to do some of the work of absent members. Each practitioner who avails himself of the scheme is required to contribute £4 4s a week for the first and second week of his absence, £6 6s for the third and fourth week, and £8 8s for the fifth and any further week. The general expenses of the scheme are a first charge on the fund so created, and the balance is distributed in proportion to the number of units to the credit of each practitioner sharing in the work. A somewhat similar scheme has been arranged by the London Panel Committee.

In those districts where successful holiday schemes are in operation the local practitioners are necessarily on good terms with each other, and the practices are carried on with due regard to the best ethical traditions of the profession. It is satisfactory to know that such arrangements are becoming more general every year. In many cases, however, it is not possible for local practitioners to undertake all necessary deputizing for each other, more especially at busy times, and for various reasons a whole-time locum tenens must sometimes be obtained from elsewhere.

AGENCIES AND FEES

Every medical agent has a list of medical practitioners willing to undertake the work of a locum, and can usually supply a locum suitable for the particular kind of work to be done. Great care must always be taken to verify the registration of anyone employed as a locum tenens, even when recommended by a medical agency. During the last few years many instances have occurred of unqualified persons obtaining such posts, and in one particularly flagrant case,

investigated by the Medical Defence Union, the same individual had been sent to no less than three practices by an agency before it was discovered that he possessed no qualifications whatever. The best medical agencies make it their business to inquire carefully into the suitability of those they recommend, and unless a principal is so fortunate as to have personal knowledge of a practitioner who is available to take charge during his absence, he will be well advised to rely upon the experience of a good agent rather than to employ a complete stranger on the strength of any assurances. Moreover, when a locum tenens has been employed who is satisfactory, it is very advisable that the principal should endeavour to obtain his services each year.

The fees now paid to a locum tenens vary usually from seven to ten guineas a week, the employer providing full board and lodging and all travelling expenses. It would obviate many difficulties if the principal would explain his domestic arrangements beforehand, the amount of alcohol he allows, the limits he imposes on the use of his motor-car, and other small points, which, if undefined, may be a cause of friction. The engagement commences from the time the locum leaves his home or the agent's office, and includes the time occupied by his return journey. Temporary engagements are usually on a weekly basis, and sometimes by the day only, it is rarely that monthly contracts are made.

The principal is entitled to receive all fees earned by the locum, including fees for attending court, or inquests, or for performing post-mortem examinations, though if any such work has to be done after the engagement has terminated the locum is entitled to retain the fees or to be suitably recompensed for the work.

RESTRICTIVE COVENANTS AND QUESTIONS OF OBLIGATION

Although owing to the temporary character of many engagements formal written contracts are frequently dispensed with, it is desirable to have a properly drafted agreement

in every case, and the agreement should include a restrictive covenant against practising within a stated distance for a reasonable period of time. This proves of special value if the principal should die and the sale of the practice become necessary. But in all cases where this precaution is omitted there is a danger of trouble arising. Complaints are frequently made that a practitioner has established himself in a district where he has previously been employed as a locum tenens. This does not imply that a man who has acted as a locum tenens in a particular place, possibly for only a week, is for ever debarred from setting up in practice in that locality. But it must be admitted that a man who sets up in practice in a neighbourhood where he had formerly been employed as a locum tenens for any length of time, even if he invariably refused to attend any of the patients of his former employer, would expose himself to suspicions which might injure his professional reputation.

When a locum tenens is obtained from a medical agent a fee is usually charged to the principal, payable as soon as the appointment is made. A similar fee is also charged if the principal at any time re-engages the locum, unless it should be done through another agent. If a locum tenens subsequently buys the practice, or a share in the practice, the principal may become liable for commission to the agent on the purchase money, though in some cases the agent stipulates that the commission will only be payable if the purchase of the practice, or of a share, is made within eighteen months of the introduction as locum tenens. The medical agent also charges the locum tenens a commission on the salary received, and if the locum tenens should be re-engaged as locum tenens or assistant, except through another agent, a similar commission is payable. If the locum tenens be admitted into partnership without payment of a premium, such commission, if any, as is payable to the agent who originally introduced the locum tenens, is usually based on the gross value of the share taken over by the locum tenens.

It is important for the principal to remember that the cost of employing a locum tenens—namely, the fees paid to the locum tenens and the cost of housing and feeding him—should be charged as expenses of the practice when making the returns for income tax

In law the principal is responsible for the consequences of any act of his locum tenens performed in the course of his employment and duty, this being the ordinary responsibility of the principal for the acts of his agent. But the locum tenens also is responsible in law for his own acts, and the aggrieved party has the right to select whether he will bring the action against the principal or against the locum tenens, or against both. It is most desirable, therefore, that the locum tenens should be a member of one of the Defence Associations, and this might reasonably be made a condition of his employment.

CHAPTER VI

MEDICAL ASSISTANTS

The Contract Law and Custom—Relations between Principal and Assistant—Remuneration and Restrictive Covenant

THE assistant in a medical practice must himself be a registered man, and the fact of registration should be verified in every case. The greater number of assistants are comparatively newly qualified men, who, after holding various resident appointments in hospital, are anxious to acquire an insight into the details of medical practice before setting up on their own account. An assistantcy with a view to partnership should only be entered upon when there is a definite agreement, signed by the principal, to offer the assistant a partnership at a definite date on terms, the more important of which should be specified in the agreement.

THE CONTRACT LAW AND CUSTOM

The legal relationship of principal and assistant in a medical practice is that of master and servant. It necessarily follows that the assistant becomes the agent of the principal for certain purposes, and that the ordinary principles of agency apply. The contract should in every case be made in writing, however short the period of the engagement, and should include the following principles drawn up by the British Medical Association.

- 1 The assistant to give diligent and faithful service
- 2 The assistant to give his whole time and attention to the practice under the direction of the principal
- 3 The assistant to receive from the principal periodic payment for his services
- 4 The assistant to keep just accounts and pay over to the principal all moneys received on behalf of the practice

- 5 Provision for a holiday for the assistant
- 6 Provision for the determination of the agreement
- 7 Period for the duration of the agreement
- 8 A restrictive clause as to practice during and after termination of the agreement

9 A provision that both the principal and the assistant should be members of one of the Medical Defence Societies during the whole period covered by the agreement, and for the settlement of disputes by arbitration

10 That if the principal requires the assistant's name to be put upon the insurance panel the assistant must agree that either the assistant shall not accept any insured person other than in the name of, and on behalf of, the principal, or, if any insured persons are accepted in the name of the assistant, he shall take every possible means to ensure the transfer of those persons to the list of the principal on the termination of the agreement

The agreement must bear the proper stamp, and should be drawn up by a solicitor who has been fully instructed as to the requirements of the case. Where no contract exists, or the agreement does not specify what notice shall be given to determine the contract, the following customs have been held to prevail in the profession

1 In the case of a permanent assistant, engaged nominally for the year, where the salary is paid weekly, the custom is to give and require a month's notice

2 An indoor assistant, or an outdoor assistant living in lodgings, or in a house furnished and provided by the master, may be dismissed, at any time, by a month's notice, or on the payment of a month's salary

3 An outdoor assistant, living in lodgings, or in a house furnished and provided by himself, by the wish, or with the consent of the master, may be dismissed, at any time, by a three months' notice, or on payment of an equivalent salary

4 Where an outdoor assistant, at the suggestion of the master, takes an unfurnished house, upon a yearly tenancy, terminable by a quarter's notice, at any quarter-day, and furnishes such house himself, it is customary for the master to give a three months' notice, terminating on the next ensuing quarter-day

5 Where the master provides the house or rooms for an outdoor assistant, and the assistant provides the furniture, it is usual to give a three months' notice

An assistant is legally bound to obey all reasonable and lawful orders of his principal, and may be dismissed without notice for wilful disobedience, gross misconduct, negligence, incompetency, or permanent disability through illness. The contract of service is dissolved by the death or bankruptcy of the principal. The principal must indemnify the assistant from the consequences of all lawful acts done in pursuance of his duties. This does not apply to the ordinary risks of a medical practice—e.g. the danger of attending infectious diseases. In law the principal is responsible for the consequences of any act of his assistant performed in the course of his employment and duty, this being the ordinary responsibility of the principal for the acts of his agent. But the assistant also is responsible in law for his own acts, and the aggrieved party has the right to select whether he will bring the action against the principal or against the assistant, or against both, and both should be members of one of the Defence Associations.

REMUNERATION AND RESTRICTIVE COVENANT

The remuneration of an assistant varies in different practices according to the amount of work to be performed, and according to whether his board and lodging are paid for by himself or by his principal. Not infrequently a commission is paid in addition to the salary, either on midwifery cases attended, or in some instances a percentage is given on all receipts of the practice over and above a stated amount, to encourage the assistant to make every effort to increase the takings beyond that figure. An assistant rightfully discharged has no claim against his principal for salary for the broken period of service. When an assistant is engaged by a firm of partners, any partner has a right to terminate the engagement, so long as his action is ratified by the other partners. But if one partner tells the assistant to remain, the latter will be within his legal rights in disregarding the notice to leave. A principal can recover fees for attendances given by an assistant, so long as the services of the assistant have been accepted by the patient.

In the absence of any specific agreement to the contrary, all professional fees paid to an assistant, including fees for notification of infectious diseases, for attendance at inquests and court cases, and for performing post-mortem examinations on the direction of a coroner, belong to the principal. It is customary for the principal to pay the travelling expenses incurred by an assistant for the purpose of taking up his appointment, and for the assistant to pay his own expenses when he leaves.

Assistants are obtained by personal recommendation, by advertisements in the medical journals, and through a medical agency. In the latter case the agency accepts a certain responsibility, and should be informed at once if the assistant should prove unsatisfactory. The restrictive clause which it is now customary to introduce into an agreement with an assistant is of great importance. The radius within which and the length of time during which the assistant shall be debarred from practising in the locality vary according to the class of practice and the nature of the district. The prohibition is usually less severe than in the case of a partner, but should be sufficient to protect the principal from serious opposition. On the other hand, it must not be made wider than is reasonably necessary for this purpose, or it might be declared null and void, as contrary to the public interest. It should particularly be observed that the restraint is not removed by the death of the principal or by his retirement from practice.

CHAPTER VII

MEDICAL PARTNERSHIPS

Nature of the Contract—Drawing up the Agreement—Reciprocal Responsibility—Division of Labour—Assistance with a View to Partnership—Dissolution of Partnership

IT is no longer easy for an individual medical practitioner to cope single-handed with the various aspects of disease met with in general practice. Twenty or thirty years ago medical practitioners were more generally content to practise independently.

It is now realized that many advantages can be gained by cooperation, and it is not at all unusual to find multiple partnerships in which the different members of the firm specialize in various departments of medical work to the benefit of all concerned. A firm of medical partners which includes an operating surgeon, an obstetrician, an X-ray operator, an oculist, and possibly an ear and throat specialist, is able to cope with almost any conceivable variety of ailment which may be met with in practice, without any necessity for calling in outside help, and therefore occupies a very strong position as compared with an isolated individual practitioner who must necessarily refer his patients to an independent specialist in many circumstances. Moreover, since the introduction of the Insurance Act, it has become more difficult for a young medical practitioner to acquire a practice by the simple process of putting up his plate. It is therefore not surprising to find that medical partnerships are becoming more numerous.

The advantages are obvious. Responsibility can be shared, the capital value of the practice can be maintained better, outside competition can be more easily met, holidays can be arranged without loss, and team-work can be carried on with all its benefits. It has to be ad-

mitted that a man who enters a medical partnership must be prepared to sacrifice a certain amount of independence, but the advantages to be gained are so great that there is no doubt the arrangement would become far more general, except for the differences that not infrequently arise

Experience in adjudicating in many partnership disputes has convinced the two great Defence Associations that many of the difficulties peculiar to medical partnerships can be obviated. No medical partnership can be carried on satisfactorily unless there is mutual goodwill between the partners. Consequently, anything likely to become a cause of disagreement must be avoided studiously from the outset. Jealousy is perhaps the rock on which a medical partnership is most likely to be wrecked, and should be carefully guarded against. Mutual trust and loyalty are essential.

NATURE OF THE CONTRACT

If a partnership is entered upon for a short fixed period, at the expiration of which both partners may continue practising in the place, not only is the saleable value of either partner's share negligible, but there is a distinct inducement to each partner to compete with the other for a hold on the patients. It is therefore preferable that the duration of a medical partnership should be for the joint lives of the partners, with provision for either partner to dispose of his share after giving the requisite notice, except in those cases where a brief partnership is arranged deliberately with a view to the acquisition by the junior partner, after a specified period, of the whole practice.

In all partnerships with a view to succession, it is desirable that the date of the retirement of the senior partner should be definitely stated in the agreement, and also the terms upon which his share in the partnership shall be acquired by his successor. An ordinary partnership should be terminable by either partner giving due notice at any time after the first few years, so that, if either partner finds the partnership unsatisfactory, it is possible for him to dispose of his share and thus withdraw from the partnership. It

should, however, be an essential proviso that the retiring partner may not continue to practise in the district

A medical practitioner who enters into partnership with one or more other medical practitioners necessarily finds himself bound by the ordinary obligations imposed upon any persons "carrying on a business in common with a view to profit" But a partnership between two or more medical practitioners differs in some respects from a partnership between persons engaged in any other profession or trade Medical partners hold little joint stock, their principal partnership asset is the goodwill of the practice Consequently, the profits of the partnership are not derived from the share which each partner has in the partnership assets, but from the professional work of each partner

From the strictly legal point of view a partnership may be created by a verbal contract, or may even be inferred either from the fact that the profits of a joint business are shared, or that the parties allow their names to appear in such a way as to imply that they are carrying on the practice as partners In all medical partnerships it is essential that a formal agreement of partnership should be entered into and signed before any act of partnership is performed Too often, as soon as a medical partnership is decided upon, the work of the partnership is allowed to commence before many necessary details are settled Months, and, in some cases, several years, have been known to elapse before the actual legal agreement was even drafted If any disagreement should then arise, the position may become complicated, and disaster may result

DRAWING UP THE AGREEMENT

The agreement of partnership is a most important document It should invariably be prepared by a solicitor who, is experienced in the peculiar difficulties which are likely to arise in connexion with medical partnerships, and who is therefore able in a great measure to guard against them The slightest ambiguity in the wording of a clause in the partnership agreement frequently leads to serious differences

All partnership agreements should define

- 1 The duration of the partnership
- 2 The terms on which the share of the incoming partner is to be acquired, and the terms on which his share may be increased from time to time
- 3 The mutual rights and duties of the partners
- 4 The property of the partnership
- 5 The expenses to be met by the partnership
- 6 The fees to be charged
- 7 The terms of dissolution in varying contingencies, including the restrictions to be imposed on a retiring or outgoing partner
- 8 The procedure to be adopted in the event of any disputes between the partners

Other matters properly to be included are provision for the keeping and auditing of the accounts, for periodic division of profits, for holidays, and for dealing with prolonged absence or incapacity of either partner. Whenever a medical practitioner contemplates entering into a partnership, a careful investigation of the books of the practice should be made by a competent accountant, experienced in medical book-keeping. This is as essential in purchasing a share as when a practice is to be bought outright, but is a precaution too frequently dispensed with. The value of the information on book-keeping given in the Appendix will be apparent.

It is also well to make sure that a prospective partner is duly registered. There are several cases on record where an unqualified person has successfully represented himself to be registered, and has been taken into partnership without any suspicion being aroused or inquiries made.

A partnership agreement may always be varied by the consent of all the partners. Many difficulties and disputes would be avoided if any departure from the strict letter of the partnership agreement made with the consent of all the partners were recorded in writing, as frequently such consent may be inferred too readily from the circumstances of the case. It has been held in some instances that the

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constant usage of partners is sufficient to supersede the articles of partnership. This must not, however, be taken to mean that an occasional failure to comply with the strict letter of the agreement invalidates the written provisions.

RECIPROCAL RESPONSIBILITY

Every partner is entitled to take his share in the management of the business of the partnership, and is under an obligation to devote himself diligently to the work of the practice. Special importance attaches in the case of a medical partnership to the following clause in the Partnership Act, 1890

§ 10 Where, by any wrongful act or omission of any partner acting in the ordinary course of the business of the firm, or with the authority of his co-partners, loss or injury is caused to any person not being a partner in the firm, or any penalty is incurred, the firm is liable therefor to the same extent as the partner so acting, or omitting to act

This means that each partner in a medical firm will be responsible for any other partner's negligence or malpraxis. It is consequently usual to include in a partnership agreement a clause whereby each partner is required to make good any loss occasioned to the firm by negligence or misconduct on his part. The most desirable arrangement is to stipulate that all the partners should be, and remain during the continuance of the partnership, members of one of the Defence Associations, and preferably that all should belong to the same society.

It is usual for each partner to provide his own surgical instruments, and also to provide his own means of locomotion. But special arrangements must be made in exceptional circumstances.

DIVISION OF LABOUR

The division of the work among medical partners is a matter of arrangement, but the general principles should be decided beforehand, and embodied in the agreement. When

a younger man is taken into partnership by an established practitioner who wishes to be relieved of some of his work, it is only right that the senior partner should decide largely which cases should be seen by the junior. This does not mean that the junior should be treated as an assistant, and many promising partnerships have been ruined by unfair treatment in this respect. The junior must reasonably expect to be given the less important work for a time, but his rights as a partner must not be infringed. For instance, it would be unreasonable for the senior partner to expect his junior partner to take all night calls and midwifery, unless it was a special arrangement agreed to before the partnership was entered into, in which case it should be embodied in the terms of partnership.

The position is different when the partnership has been arranged with a view to the succession of the junior within a comparatively short period. His effective introduction is essential to the proper transfer of the goodwill, and must not be unduly delayed. A judicious arrangement of the work with due regard to the susceptibilities of the patients should be possible, and must be insisted upon. When there are more than two partners, any difference arising as to ordinary matters connected with the partnership business may be decided by a majority of the partners.

ASSISTANCE WITH A VIEW TO PARTNERSHIP

No one should consent to act as an assistant with a view to partnership on a mere verbal assurance that he will eventually be admitted into partnership. Too often it is found that the intentions of the principal change, and that after repeated delays some more or less imaginary reason is advanced for not carrying out the original intention. When a preliminary service as an assistant with a view to partnership is suggested, it is well to insist that a definite agreement for partnership, to commence on a future date specified in the agreement, shall be entered into and signed by both parties. To guard against incompatibility, liberty should be given to either party to cancel the agreement.

within a specified period, not exceeding six months, in which case the proposed partnership would be nullified.

The position of the assistant as a purchaser on some agreed terms of a share of the practice in which he is working is dealt with in the next chapter

DISSOLUTION OF PARTNERSHIP

A certain proportion of partnerships fail because the partners are temperamentally incapable of carrying on together. When this occurs the partners cannot be too vehemently urged to keep out of the law-court. If they are so unwise as to take their disputes to law they will in great probability involve themselves in a distressing and expensive struggle, which will injure them and perhaps discredit in the public eye the profession to which they belong. In any such case, when action has been brought, the Court, recognizing these things, is likely to intervene and to press the parties to settle, it being obviously futile to run up lawyers' bills to obtain the dissolution of a partnership intolerable to both parties. Heavy costs and most unfortunate publicity will be saved by a simple mutual agreement to dissolve. The return of purchase money will usually be the stumbling block, but the parties can refer this point to some arbitrator in whom both have confidence, agreeing to abide by what he considers reasonable. Once personal charges which may suggest fraud or immorality, and not stop at incompetence or incompatibility, are launched a professional man must fight them with his last penny. It is the duty of the Defence Associations to obviate such occurrences.

Many partnership disputes will be avoided at the outset if books are properly kept and properly audited. It should never be possible for a partner to plead that he has been deceived in a bargain. The auditor, however, and the lawyer who draws up the agreement, can give no advice upon incompatibility of temperament, nor does the law provide any elastic method of dissolving partnerships which fail for purely personal reasons.

The Partnership Act terminates partnerships automatically in certain circumstances, such as death, bankruptcy, illegality, expiration of the term agreed, etc., and allows a court to dissolve partnerships if a partner

(a) Is a lunatic, or

(b) Becomes in any other way permanently incapable of performing his part, or

(c) Has been guilty of such conduct as, in the opinion of the Court (regard being had to the nature of the business), is calculated to affect prejudicially the carrying on of the business, or

(d) Wilfully and persistently commits a breach of the partnership agreement, or otherwise so conducts himself in matters relating to the partnership business that it is not reasonable for the other partner or partners to carry on the business in partnership with him, or

(e) When the business can only be carried on at a loss, or

(f) Whenever circumstances have arisen which, in the opinion of the Court, render it just and equitable that the partnership be dissolved

In (b), (c) or (d) the Court will not act at the instance of the partner who is to blame, and there has been little decision on what kind of circumstances would make dissolution just and equitable under (f). Prejudicial conduct under (c) depends upon the nature of the business, adultery by a partner would not justify the dissolution of a partnership of merchants but might be sufficient reason for dissolving a medical partnership. Wilful persistent breach of contract under (d) has been explained to mean "studied, prolonged and continued inattention to the application of one party calling upon the other to observe the contract". Unreasonable conduct does not mean mere squabbling and ill-temper, but a state of complete and permanent animosity making an impassable breach between the parties and destroying mutual confidence.

These are the legal considerations, arbitration and the services of the Defence Associations can usually secure a just settlement of situations where the law courts are powerless

CHAPTER VIII

THE TRANSFER OF PRACTICES

Points for the Purchaser—Types and Price of Practices—Transfer of a Share—Restraining Clauses on Vendor—Points for the Vendor—Warnings to both Parties

A MAJORITY of medical men have at some time in their professional career to consider the purchase of a medical practice, or a share in a medical practice. This is a matter of the utmost importance, and an initial mistake may have disastrous results for an unwary purchaser. The whole of the average medical man's professional education, from the time when he first commences his studies, is devoted to professional subjects. He receives no training or information in what may be called the business side of his profession, and as a consequence it is usually found that when he wishes to commence practice, he has very little idea how to set about acquiring a practice, what price he should pay, and generally what steps he should take to ensure that he is adequately protected from the pitfalls which await him, and which could be guarded against by the exercise of proper care and foresight.

(1) POINTS FOR THE PURCHASER

Types and Particulars of Practice

The first point for decision is the type of practice to be acquired. Whether it is situated in the country or in a large town, and whether the patients are mainly drawn from the well-to-do or the poorer classes of the population, and whether there is to be particular scope for surgery or any particular branch of medicine, all raise different points for consideration.

Having decided upon the type of practice, the medical man's next step is to obtain particulars of such practices

as are for sale of the type required This is done by watching the advertisement columns of the medical press, or by application to medical transfer agents for particulars of any practices they may have upon their books The particulars to be supplied from either source, to enable the prospective purchaser in the first instance to satisfy himself that the practice offered for sale warrants further inquiry, are shortly as follows The annual gross receipts from the practice for the immediately preceding three years, the average number of confinements and fees receivable therefor, the scale of fees charged to private patients, information showing how long the practice has been established, number of panel patients, what appointments are held, and whether these are transferable Full particulars should be obtained as to the residence available for the purchaser, and as to any separate surgery used in connexion with the practice, and it should also be stated whether the vendor has been in the habit of doing his own dispensing Finally the price asked must be named

With this information before him the prospective purchaser will be in a position to judge whether or not the practice is likely to satisfy his requirements If he considers that it will, he should arrange an appointment to interview the vendor At this interview he will, of course, in the first place have regard to the neighbourhood, and make general inquiries as to the number of medical men already practising in opposition in the district, the probability or otherwise of extending the practice, the expense of running it, and whether it affords adequate opportunities for the practice of any branch of medicine or surgery to which the applicant has any special leaning

The residence and surgery accommodation offered should also receive special thought The importance of this matter frequently receives insufficient consideration The house comprises a very material item in the goodwill of a practice, and it is therefore of great importance that, if possible, the residence and surgery should be purchased, or failing this that a sufficiently long lease should be secured.

to afford adequate protection to the purchaser. There have been cases where a purchaser has acquired a practice without sufficient security of tenure of the house, with the result that very shortly after the completion of the purchase he has received notice to quit. At the best in these cases he is put to the expense of finding other accommodation which may be very unsuitable, at the worst he may be quite unable to find any accommodation, in which event he can say good-bye to the practice. Or a rival practitioner may acquire the house, and in so doing he will undoubtedly also take over some of the patients with the house.

Purchase Price

If these preliminary inquiries prove to be satisfactory, the next, and all-important question of the purchase price has to be examined. The purchase price of a medical practice is invariably based upon a number of years' purchase of the average gross receipts. It is usual to work out the average gross receipts for this purpose from the three years immediately preceding the date of purchase. It is difficult to lay down any hard-and-fast rule as to the number of years' purchase which should be paid, as this must of necessity vary with the individual circumstances. A fair price to pay for a practice with an adequate introduction is one and one half years' purchase, but when purchasing a practice on the death of the incumbent, one year's purchase is as a rule the maximum amount which should be paid for an immediate succession. The value of a practice on a death vacancy, however, rapidly declines, and if more than a month has elapsed since the death of the prior incumbent, the price should be less than one year's purchase.

Partnership

If the practice offered is a share in a partnership, two years' purchase is the usual price, but this again varies according to the class and character of the practice.

It is sometimes arranged that the purchaser of a share

in a practice shall for a preliminary period of from three to twelve months be employed as an assistant in order that he may obtain a thorough knowledge of the practice. In this event the purchaser enters into an agreement with the vendor to serve him as assistant for the period arranged, and the agreement contains an option on the part of the purchaser to purchase a share in the practice on agreed terms, on giving notice before a specified date. It is felt by some that this is not a good method of being introduced, as the patients may for some time afterwards regard the purchaser as only an assistant, and there is a preference by patients to be attended by a principal. But it is customary in this situation for the senior man to speak of his junior colleague in such a situation as a partner, even before he actually is so, a courtesy that has much to recommend it.

Another and perhaps more frequent method is for the purchaser to enter into preliminary articles of partnership with the vendor for a period of from one to five years, and in this event the articles of partnership contain all the usual provisions, and, in addition, a right for the purchaser to buy the whole of the vendor's interest in the practice within an agreed period, or upon the prior death of the vendor. This is a useful method where an elderly practitioner is desirous of gradually retiring from his practice, and from the point of view of the purchaser has the advantage of giving him a prolonged and gradual introduction to the patients, but, not unnaturally, the purchase price under such circumstances would be higher than it would be in the case of an ordinary out-and-out purchase.

The points which may arise on entering into a partnership need no repetition, but it is well to insist again on one thing of great importance, which is sometimes not regarded with sufficient care, and that is the question of compatibility.

With the exception of marriage, there is no relationship which binds human beings together so closely as a partnership. It therefore behoves a would-be partner to study the character of the person or persons with whom

he proposes to enter into such close contractual relationship, having regard to the fact that the success or otherwise of the practice will depend on how well the partners work together for the mutual good of the partnership. If there is any friction or disagreement between partners, or if there is any lack of confidence or goodwill between them, a position arises which makes it impossible for the practice to be worked to the best advantage, and may ultimately end in litigation or arbitration proceedings involving heavy expense.

Investigation by an Accountant

Sometimes it is agreed that the purchase price shall include the vendor's stock of drugs, drug bottles, surgery fittings and effects, and sometimes these are taken over at a valuation. This point should be made clear in arriving at the purchase price. The purchaser should agree the purchase price with the vendor, subject to proper investigation of the vendor's books and practice records, in order that the vendor's representations as to the receipts of the practice may be verified. This investigation should be undertaken by an accountant, who should preferably be one who is used to the peculiarities of medical practices. A vendor who declines to afford facilities for investigation of his books should be regarded with suspicion. A purchaser who neglects to make the usual and reasonable investigation will find difficulty in obtaining relief from the courts if he discovers after completion of the purchase that the practice is not so good as he expected, for a little vigilance on his part would have been sufficient to disclose the true state of affairs. There is a maxim of law which every purchaser should keep well before him, and that maxim is "caveat emptor."

It is inadvisable to have anything to do with a vendor who claims that he keeps no books, or that they do not show the full receipts "because of income-tax." The purchase price should only be based upon such figures as can be proved by properly kept accounts (see Appendix)

Appointments and Panel Practice

Difficulties may arise with regard to appointments held by a vendor. If the income from such appointments is included in the average gross receipts of the practice for the purpose of arriving at the purchase money, the purchaser should insist that, in the event of any such appointment not being obtained by him within a period of, say, six months from the date of the purchase, so much of the purchase money as is attributable to the remuneration from any appointment not obtained by the purchaser shall be refunded to him. The vendor in such cases will in turn insist that the purchaser should do his utmost to obtain all the appointments. It is a point, however, to be remembered here, that application for many appointments can be made by other practitioners when a vacancy occurs on the death of the holder or on the sale of the practice, as no vested interest in them exists.

The amount of the capitation fee payable under the National Health Acts is modifiable at certain dates, and a purchaser should require that in the event of the capitation fee being reduced within one year of the date of purchase, the purchase money should be calculated upon such reduced fee, and the difference should be refunded to him. Care should be taken by the purchaser in agreeing the purchase price that an allowance is made in respect of any reduction in the per capita fee under the National Insurance Acts, where the period covered by the average gross receipts of the practice for the purpose of arriving at the price includes such fees at a higher rate than that current at the time of purchase.

Adequate Introduction

A purchaser should insist upon the vendor giving him adequate introduction to the patients of the practice. What is an adequate introduction varies according to the different types of practice. It will, for instance, be longer in a scattered country district than in a closely populated

industrial district The introduction to a high-class practice has to be carried out as gradually as possible and with tact The purchaser should bear in mind in discussing this point that the introduction is really the only tangible part of the goodwill which he is purchasing A clause should be inserted in the assignment of the practice to the effect that in the event of the agreed period of introduction being curtailed by the death or permanent incapacity of the vendor, there shall be a reduction of the amount of the purchase money, proportionate to the time by which the period of introduction is curtailed In purchasing a practice on the death of an incumbent much may be done by way of introduction by the relatives of the deceased, and this should be stipulated for

Great care should be exercised that any circular letter which is sent out is so worded as to give no offence to other practitioners in the neighbourhood Such circulars should not contain anything which savours of an advertisement or puff, and must only be sent to persons whose names appear upon the books of the practice as having been patients within the last three years immediately preceding the transfer of the practice

If an adequate introduction is not agreed to by the vendor some reduction should be made in the purchase price by way of compensation During the period of introduction it is usual for the expenses and profits of the practice to be shared equally between the vendor and the purchaser An alternative is for the purchaser to bear all the expenses and receive all the profits, and to pay the vendor a fee at the rate usually paid to a locum tenens in the district The purchase money should be paid, as to part, on the commencement, and, as to the balance, on the conclusion of the period of introduction

Restraining Clauses

In order to safeguard the practice to the purchaser he must insist upon the vendor entering into an adequate covenant restraining him from practising in any capacity

within a given radius from the centre of the practice—usually taken from the practice house. The extent of the radius varies according to circumstances, but it should not be made wider than is reasonably necessary for the protection of the purchaser. It is useful to agree that any question, dispute, or difference shall be settled by arbitration. This method of settling disputes avoids the possibly harmful publicity which an action would entail.

It is usual for the stamp duty upon the assignment of a medical practice to be shared equally by the vendor and purchaser. In the absence of an express stipulation to this effect, however, it would fall upon the purchaser. He should, therefore, arrange with his vendor that this expense should be shared. Care should be taken that the assignment is properly stamped. If it is not so stamped, any party to it will have to pay the stamp duty and a penalty before the document can be used in any court of justice.

A General Warning

A purchaser should not sign in any case a definite offer to purchase until he has received his accountant's report. If he signs an offer it should be made subject to investigation and satisfactory report by accountants, and subject to approval of the necessary documents by his solicitors. A purchaser should not commence work in the practice until all his investigations are satisfactorily completed, and the necessary assignment of the practice is signed and completed. A purchaser should insist on the employment of a solicitor to approve the documents in connexion with the purchase on his behalf. It is astonishing how often medical men—who in their own profession would have nothing to do with unqualified persons—are content to allow agents and persons without any legal training to prepare legal documents for them. Experience has shown how essential it is that such documents should be prepared by persons properly qualified to do so. Questions involving difficulty and expense frequently arise upon the construction

of badly drawn or incomplete documents. It then becomes necessary to seek legal advice, and to incur expense which might have been avoided if a solicitor had been consulted in the first instance.

(2) POINTS FOR THE VENDOR

Employment of an Agent

Having decided to sell a practice, the vendor's first step is to get in touch with likely purchasers, that he may place before them as clearly and concisely as possible full details of the practice. To this end a vendor should consider first whether he desires to employ the services of an agent or to get in touch with prospective purchasers direct through the medium of an advertisement in the medical press. If the former course is decided upon, he should be careful to select a reputable medical transfer agent upon whom he can rely to safeguard his interests.

In employing an agent the vendor should realize that the agent's commission is payable by him as vendor, and before giving definite instructions for the disposal of the practice he should ascertain the scale of such commission, and on what it is actually based and to what it extends. Further, in order that there should be no possibility of dispute at a later date, he should take care to agree when such fee shall be deemed to be earned by the agent and payable to him. For example, whether when the contract is signed, when a willing purchaser is introduced, or when the purchase money is actually paid.

It is inadvisable to instruct more than one agent, for if, as sometimes happens, particulars of the practice are sent to a purchaser by more than one agent, they may both claim commission as being the agent instrumental in effecting the sale. Some of the better-class agents have a mutual arrangement by which in such circumstances the commission is divided between them, or else an agreement between them provides for the ready determination of the question. Unfortunately, all agents are not parties to such an arrangement, and in case of dual claims difficult questions

will arise as to which agent actually introduced the purchaser, and in the end the vendor may have to pay two or more commissions. This danger can be met by arranging with the agents when instructing them that, if any such question does arise, only one commission shall be payable, which must be shared amongst them.

If the vendor prefers to dispense with the services of agents, he can do so by inserting his own advertisement in the medical press. In this event, he should take care not to give full indication of his identity or the exact locality of his practice, as it is in some cases very damaging to the practice if the patients hear that there is likely to be a change before the purchaser is actually introduced into it. In addition there is the danger of a not too scrupulous agent taking advantage of the knowledge thus gained to introduce a purchaser, thus trying to establish a claim for commission.

Supply of Information

Having placed the disposal of the practice in train, the vendor must be prepared to supply all reasonable information which a purchaser may require. It is important to keep clear and accurate accounts of a practice in such a form that an accountant or other investigator of the figures on behalf of a purchaser can easily follow them so as to check the gross income for the purpose of verifying the purchase price, and to ascertain the various sources from which the income is derived.

The purchase price is usually based upon an agreed number of years' purchase of the average gross receipts for the three years immediately preceding the date of purchase. In order to enable the investigator to verify the earnings of the practice, it is most advisable to pay all takings from the practice into a banking account, whether such takings are received in the form of cheques, postal orders, or cash, as by so doing the bank pass-book acts as a check upon the figures shown in the books of account.

The scope of the inquiries which a careful purchaser should make when investigating a practice offered to

him for sale has been indicated, and the vendor should be prepared with all the information there suggested. He should obviously take care to state fully all the advantages of the practice, but it is of equal importance that he should not conceal or withhold information which might affect a purchaser in deciding to buy. It is true that the legal maxim "caveat emptor" applies to these transactions, but this would not be an adequate defence to an action for damages by a disappointed purchaser where there has not been a full disclosure of material facts or where there has been misrepresentation of facts. For his own protection, too, the vendor must bear in mind that whatever he may do he cannot guarantee that his successor will retain the practice which he has bought, so he should ensure that, even though disappointed, the purchaser can have no claim upon him for his lack of success.

It should also be borne in mind that litigation even for the successful litigant is an expensive matter, and so the vendor should be careful to lay before the purchaser everything which is material.

Payment by Instalment

It should be remembered that the prices referred to, when discussing the purchaser's position, relate to an average practice possessing no specially attractive features. Where such features exist, a vendor may ask and expect to receive an increase upon such average purchase price commensurate with the special features. He should remember that the amount to be realized is ruled by the question of supply and demand when dealing with medical practices as much as in dealing with commercial commodities.

Having encountered a purchaser, and having satisfied his inquiries, it is often found that such purchaser is unable to pay the whole of the purchase money in cash, and accordingly may ask to pay for the practice by instalments. A vendor will often be well advised to accept payment in this manner, provided that a substantial amount is paid down in cash and adequate security is given for payment of the balance,

and also that interest is paid upon the balance from time to time outstanding. It is, of course, essential to examine the security offered somewhat critically, as once a purchaser has entered into possession of the practice it will certainly be difficult and often disastrous for a vendor to return to it if the purchaser makes default in payment.

Security for Deferred Payment—The security may take a variety of forms. The most usual is a guarantee by some third person, a deposit of actual securities, or, in the case of a panel practice, a charge on the panel receipts. When a guarantee is offered, the vendor should obviously make careful inquiries as to the financial standing and position of the guarantor. The guarantee can be effected either by joining the guarantor as a party to the assignment of the practice from the vendor to the purchaser or by separate instrument. It is well, in the second alternative, to point out that when a life assurance policy is offered as security, its surrender value should be ascertained and it should only be regarded as an actual security to the amount of the surrender value. A new policy which has acquired no surrender value is therefore of no actual security, except in the case of the death of the purchaser before the whole of the purchase money is paid. From this aspect a life policy is a good security, but it should be considered as a collateral only and not a primary security.

The charge upon the panel receipts—which is perhaps one of the most satisfactory forms of security—is effected by the purchaser agreeing with the vendor that the cheques payable by the insurance committee in respect of the panel patients of the practice shall be paid to the vendor until the balance of the purchase money and interest thereon is paid. It is, however, sometimes provided that such cheques shall be paid to and received by the purchaser until he shall make default in payment of any instalment or interest, in which event the vendor shall be at liberty to give notice to the insurance committee requiring the cheques to be paid to him until all sums payable have been received.

Where the purchase money is payable by instalments

the vendor should insist that, in the event of the purchaser selling the whole or any share of the practice before he has paid for it in full, the balance of the purchase money then owing shall forthwith become payable, and a clause to that effect should be inserted in the assignment of the practice to the purchaser.

Book Debts —If these are sold with the practice they must be valued in order that the purchase price may be ascertained and due allowance must be made for bad and doubtful debts. In this case, the purchaser should be given a power of attorney to enable him to collect them, such power of attorney being incorporated in the assignment of the practice. By adopting this course a vendor will relieve himself of the trouble and expense of collection.

If the book debts are not sold with the practice, it is fair that the vendor should submit to a clause in the assignment whereby he is precluded from taking proceedings to recover the amount due from any patient for a period of six to twelve calendar months from the date of the sale of the practice, except where a patient dies, becomes or is likely to become bankrupt, or leaves the neighbourhood, and except where the debt is likely to become irrecoverable by the operation of the Statute of Limitations unless proceedings are taken for its recovery at an early date. In this event, also, it is not unreasonable to allow the purchaser a commission not exceeding 10 per cent upon any book debts which he may collect for the vendor.

Restraining Clauses

A vendor must also submit to a clause in the assignment precluding him from practising within a reasonable radius from the centre of the practice. A purchaser, however, cannot ask that this radius shall be wider than is necessary for the purpose of affording him adequate protection from competition by the vendor. If it is arranged that the purchaser should have a preliminary partnership, or should serve as an assistant to the vendor before exercising his option to purchase, the vendor should insist that the

agreement should also contain a clause precluding the purchaser from practising in opposition in the event of the purchase not being completed

If the vendor is selling his practice with a view to giving up general practice and devoting himself to practice as a specialist or consultant, the clause restraining him from practice should be so worded as to permit of his intention, but in such circumstances it would not be unreasonable for the purchaser to ask for some rebate in the purchase money by reason of the fact that the vendor is allowed to attend patients of the practice even as a specialist or consultant. The vendor also might expect the purchaser to insist on the deduction from the gross receipts on which the purchase is to be based of any fees derived from consultations or from the special branch of medicine or surgery to which the vendor intends thereafter exclusively to devote himself.

The definition of the term consultant or specialist is by no means easy, but for his own protection, and in order to avoid dispute in the future, it is very desirable that these terms should be defined as closely as possible in the assignment. It will usually be of sufficient protection to the purchaser if in such cases the vendor is bound to charge a minimum fee of from two to three guineas for every consultation upon any person who has been a patient of the practice.

The vendor must also remember that the restraining clause operates not merely for the life of the purchaser, or the period of his retention of the practice, but unless restricted in point of time by the actual terms of the assignment, it attaches to the goodwill, and the benefit of it can be assigned to the successor of the purchaser, and so on, throughout the life of the vendor.

An Obvious Precaution

The warnings and comments apply equally to the sale of a share in as to the sale of an entire practice. In the sale of a share of a practice, the actual assignment is embodied

in the articles of partnership which set out the rights and obligations of the parties

One last word Every medical man, before selling his practice or a share in it, should make certain that the purchaser is a duly registered medical practitioner This may sound obvious, but experience has shown the caution is necessary, as even that excellent publication, the Medical Directory, has been misled before now, and contained the names of persons who have fraudulently assumed the name and qualifications of a deceased practitioner, and the only sure and certain test is to consult the Medical Register and there identify the purchaser

CHAPTER IX

GENERAL RELATIONS BETWEEN PATIENT AND DOCTOR

A Relation of Contract the Patient's Consent—Allegations of Negligence—Dichotomy—A Word about Gifts

It is the duty of a medical practitioner to place the interests of his patient above all other considerations, and to do his utmost to promote his patient's welfare. Registration is an implied and public warranty on his part that he possesses the requisite ability and skill, and in every case that he attends he is legally bound to employ a reasonable amount of knowledge, skill and care. In the absence of a definite arrangement that he shall not be paid, a medical practitioner is entitled (unless restrained by such a by-law as that of the Royal College of Physicians of London) to be reasonably remunerated for any professional services he may render. There is, however, nothing to prevent a medical man from attending a patient on the understanding that his services shall be gratuitous. It is commonly understood that a medical practitioner is at the beck and call of anyone who chooses to send for him. This is not the case. There is no law to compel a medical man to attend a patient, apart from any contractual obligation he may have accepted, but if he once undertakes to do so, he must not go back except at his own risk. Even if he is attending a case gratuitously, and wishes to withdraw from it, he should give the patient a reasonable opportunity of obtaining other medical assistance before he ceases attendance.

A RELATION OF CONTRACT THE PATIENT'S CONSENT

The relationship between a medical practitioner and his patient is one of contract, though usually the contract is

only implied in the rendering of services by the medical practitioner for which he can claim to be reasonably remunerated. It is as well that the scale of such remuneration should be agreed with the patient at the outset whenever possible, to avoid misunderstandings. It should never be forgotten that a medical practitioner has no right to do anything to a patient without his consent, or, in the case of a child, without the consent of the parents or guardians, save in emergencies when the medical practitioner must exercise his discretion. This applies not only to operations, but to mere examinations or any form of treatment. When surgical operations are necessary, the ideal thing is to obtain the patient's consent in writing, and as the full extent of the operation frequently cannot be determined beforehand, it is well for the surgeon to get a written authority from the patient or a near relative to exercise his discretion when the exact conditions are ascertained, but in practice this ideal can but seldom be attained. No surgeon can exceed the extent of his authority without some risk of laying himself open to a charge of assault.

As the law stands, a patient who consults a doctor gives implied consent that the doctor shall be entitled to do all such acts as he considers reasonably necessary, having regard to the state of medical knowledge, and to his own personal experience for discharging the duty of making a diagnosis. Implied consent is, however, always subject to this, that a doctor who proposes to do any dangerous or painful act, or any act causing, if successful, a permanent disability, should supply the patient with such information as will enable him to give or withhold his consent. Like the securing of written consent, this is a counsel of perfection, for often the information cannot be given. It might happen that, after obtaining the patient's consent to a certain operation, the surgeon found—say on opening the abdomen—that he could not continue with the proposed measure, or that he would have to perform another operation owing to the condition revealed. No court would be likely to award damages in such cases if there were a state

of emergency, but expensive law proceedings have shown the necessity of authorization comprehensive enough to allow reasonable latitude

ALLEGATIONS OF NEGLIGENCE

Everyone engaged in active practice, whether as general practitioner or as consultant, is liable in the ordinary course of his daily work to false charges, sometimes very serious, of professional negligence or incapacity. However well-informed a medical practitioner may be in his professional work, and however careful he may be in his treatment of a patient, he is always at the mercy of any person who may feel aggrieved. All that seems necessary from the patient's point of view, as a foundation for an action for negligence or malpraxis, is for him to conceive the idea that, however serious his disease or injury may have been, he ought to have made a more rapid recovery or obtained a more perfect result. He bolsters up his claim with items for loss of wages, loss of health, nervous shock, expenses for visits to the seaside, massage, and the like, hoping that the practitioner will submit to his demands for compensation rather than face the ordeal of a public trial. No doubt it is a great temptation to settle a claim of this kind by a small monetary payment, and so avoid the publicity necessarily involved in court proceedings, but every case that is fought and won will help to protect other practitioners from having to face similar claims.

The majority of the allegations of negligence are set up as a counter-claim against the payment of professional fees. Fortunately, it is not sufficient for the plaintiff merely to contend that he has received no benefit from the treatment. If a practitioner has exercised due care and ordinary skill, he is entitled to be paid, although his treatment is unsuccessful. The mere employment of a medical practitioner does not imply a contract to perform a cure, but only that the medical practitioner will exercise reasonable care and skill, having regard to his position and standing in the profession.

But a patient is entitled to recover damages in respect of

any injury caused through neglect or lack of skill on the part of his medical attendant, and it is a question for the jury in each case to say whether any injury is attributable to the want of a reasonable and proper degree of care and skill in the practitioner's treatment. If the jury finds that there was a lack of care and skill on the part of the medical practitioner, having regard to his status and experience, he will be held liable, but he will not be answerable merely because some other doctor might possibly have shown greater skill and knowledge.

In other words, a medical practitioner is not expected to show the highest possible skill, but he must have that amount of skill which should be possessed by a practitioner in his position. Accordingly, the degree of skill expected from a specialist will not be required from a practitioner remote from teaching centres.

A medical practitioner who is so unfortunate as to have his professional work called in question should make no reply to the allegation until he has been properly advised, it is impossible to emphasize too strongly the great protection which a practitioner derives in all such cases from membership of an experienced Defence Association. Too often when such cases come to be defended it is found that the position has been gravely prejudiced by injudicious letters which the practitioner has written without recognizing their possible effect, and in too many instances without even keeping a copy. Errors in diagnosis are not necessarily due to negligence, and no guarantee is given or implied that a medical practitioner will diagnose correctly the ailment from which his patient is suffering. Questions of this kind frequently arise in connexion with the notification of infectious diseases, and it is seldom that a verdict has been given adverse to any practitioner who has exercised care before making a diagnosis.

Attention is necessary in dealing with cases of criminal wounding, as, if the patient should die, the person who caused the wounding may be charged with murder, and may set up the defence that, but for negligence and unskilful

treatment, the original wound would not have been fatal. In all such cases the medical practitioner should be prepared to justify every step which he takes, and in grave instances should consult whenever possible with an experienced colleague. The most careful notes should be made in writing of the patient's condition when first seen, and his daily progress, with full particulars of all treatment.

The introduction of X-rays as an aid to diagnosis, and as a method of treatment, has given rise to many claims in respect of injuries received as a result of their use. Negligence may be alleged either with regard to the application of X-rays, or even in not resorting to them. The desirability of requiring a patient to sign some form of acknowledgment of the risks attaching to the use of X-rays, and his willingness to take such risks, has been frequently discussed, but no such acknowledgment would protect a practitioner from an action being brought against him for alleged negligence, and it might even be argued that its possession might have made him less careful than he otherwise would have been.

It must be remembered that a surgeon is held responsible for negligence on the part of those helping him at an operation. At such a time the surgeon is supreme, and assistants and nurses, although employed by a hospital at which the operation is being performed, cease for the time being to be servants of the hospital, and take their orders from the operating surgeon alone. The hospital does not as a rule incur responsibility, provided it has exercised due care in the selection of its medical and nursing staffs.

DICHOTOMY

The relation between the patient and the doctor being that of an implied contract, any secret profits made by the doctor are improper.

The practice of "dichotomy," or secret fee-sharing between a consultant and the general practitioner who has called him in, has medical aspects on which there can be no need to dwell, it stands condemned by all. But

the practice has also legal aspects of a serious kind. Naturally the facts differ in each case, but we will suppose that a patient is attended by a general practitioner who advises an operation or a consultation, that the patient accepts the advice and leaves it to the practitioner to arrange for the services of the operating surgeon or consultant at a particular time and for a stated fee, and that the operating surgeon or consultant, on being paid the fee, privately hands part of it over to the practitioner. At once the following legal consequences result. If it be right to speak of the practitioner as having been the patient's agent (a point which will be returned to presently) the agent has taken a surreptitious profit in the course of his agency. An agent must not enter into any transaction in which he has a personal interest in conflict with his duty to his principal, unless the principal is fully informed and consents. If the patient is unaware of what is going on behind his back, he may, when he finds out the facts, insist that the practitioner (as his agent) shall account to him for the secret profit he has received. The agent must hand it over to the patient, who otherwise can bring an action for the return of the money.

Possibly the practitioner and the consultant would plead in defence that such fee-sharing was a trade usage. For this plea to succeed the court would have to be convinced that the practice was reasonable and that it was not only common but general. There is little doubt that the practice would not be held reasonable, for it alters the nature of the contract between patient and consultant without the knowledge of the former, and it gives the agent an interest in conflict with his duty to his principal.

Civil or Criminal Proceedings

Thus far the reference has been to the legal aspect in civil proceedings. But dichotomy has a criminal aspect too. Under the Prevention of Corruption Act of 1906 "if any agent corruptly accepts or attempts to obtain any gift or consideration as a reward for showing any favour to any person in relation to his principal's

affairs or business," he is guilty of a misdemeanour punishable with a fine up to £500, or imprisonment up to two years' hard labour. Might not a jury be asked to consider that the practitioner is showing favour to a particular consultant if he recommends to the patient, and procures the services of, one from whom he has the expectation of receiving, and perhaps on similar occasions previously has actually received, a kind of secret brokerage or commission? A corresponding offence under the Act is committed by anyone who gives money to the agent in these circumstances. Finally, it might be possible to frame an indictment under another part of the Act, for the giving or showing of a receipt for the consultant's full fee might be proved to have deliberately misled the patient into the belief that the full fee had been properly received and represented a *bonâ fide* transaction.

The crux in the legal position is the question whether the practitioner acts as agent of the patient in obtaining the services of, and making the necessary arrangements with, the consultant. This is a question of fact. Agency may be inferred from the conduct of the parties. An agent is a person employed to bring the employer into legal relations with a third party. It is true that, in authorizing his doctor to obtain for him the services of a consultant, the patient is asking the doctor to do something for him gratuitously. But dichotomy puts an end to the gratuitous element in the transaction. Moreover, where the transaction is gratuitous, the only legal difference is that the parties may have no legal remedy if the transaction is not carried out at all—i.e. if the consultant's services are not obtained. As soon as the transaction is under way and the patient meets the consultant, the question whether the agency was gratuitous or not becomes immaterial. Again, the patient may pay the consultant direct, but that fact does not negative the inference of agency. And, at any rate, in the Statute which has been quoted above, there is a wide interpretation of agency. An "agent" is defined as including "any person employed by or acting for another." The position of a defendant would be even more serious in a

panel case, for the amending Act of 1916 provides that if money has been paid to, or received by, one in the employ of a Government department or public body, the transaction is presumed corrupt unless the contrary is proved

No Legal Analogy

No analogy from the legal profession can be pleaded in aid. A busy barrister sometimes (but by no means always) gives a part of his fee to another barrister who has "devilled" a case for him. Here there is no element of agency, for the recipient had nothing to do with the engagement of the barrister's services. If one could imagine a solicitor employing a barrister at a fee of 50 guineas with a secret understanding that the barrister should hand 5, 10 or 20 guineas back to the solicitor behind the client's back, or if one could imagine dichotomy between a general practitioner and the chemist who makes up his prescriptions, a truer analogy would be set up. The gist of the offence is the improper secrecy. The effect of secret fee-sharing on the relations between the medical profession and the public is easily imagined. It must inevitably suggest that the consultant's fees are artificially and unjustifiably raised in order to provide a margin to cover the secret commission, that the patient is deprived of the genuinely disinterested advice he expects from his medical attendant, and that members of the medical profession are not above petty conspiracy to hoodwink the persons who pay for their services. It is fair to say that proceedings under the Prevention of Corruption Act are seldom successfully taken, owing to the difficulty of obtaining sufficient evidence. But for a medical man even to be acquitted on such a charge would be unedifying, and, if there is doubt about the law, a practitioner will hardly desire to give his name to a leading case on the subject.

A WORD ABOUT GIFTS

Owing to the peculiarly intimate relation of a medical practitioner to his patient, any business transaction between them must be fair and above-board, and it is essential that

the patient be fully aware of what he is doing There must be no possibility of a suspicion of undue influence on the part of the medical practitioner for his own benefit This necessarily applies to any gifts from a patient to his doctor, and even to wills, whereby the medical attendant will benefit, except that in the latter case undue influence cannot be presumed, but must be proved, in order to invalidate the will The influence which a medical practitioner necessarily and naturally possesses over his patient would not of itself be a ground for setting a will aside, unless it could be shown that the testator was coerced into doing what he did not really desire to do It is very advisable, where the medical man knows that he is to be a beneficiary under a will, that he should ask the patient to act upon legal advice It has before now occurred that the spontaneous kindness of a patient has led to embarrassment where the medical man had no knowledge of what was in the patient's mind

CHAPTER X

MEDICAL SECRECY

Obligation of Secrecy Absolute—Claims of Interested Parties—Safeguard of Habitual Reticence—The Witness-box

If a man promises to keep secret the information which is imparted to him, and fails to do so, he is rightly regarded as untrustworthy or dishonourable. Patients, when consulting their medical advisers, do not ask for a promise of secrecy, because it is understood that medical practitioners are, in any case, pledged to keep secret what comes to their knowledge through the practice of their profession. Were it not so, patients would no doubt make a rule of exacting a pledge of secrecy from their medical attendants beforehand. A medical practitioner must consequently be regarded as bound by an implied promise of secrecy unless he has definitely informed his patient beforehand that he will not accept this obligation. It is, however, rightly assumed that a patient is aware that his doctor is legally bound to report cases of infectious disease to the proper authorities, to give a certificate of the cause of death, and, in general, to provide such information as is by law required. Apart from legal compulsion, the obligation of secrecy is absolute.

In Cases of Venereal Disease—It has been contended that when a man, who is known by his medical adviser to be suffering from syphilis in an infectious stage, is about to marry, a warning ought to be given to the woman who might otherwise innocently contract the disease. The wickedness of the intention should be plainly impressed upon the patient, but it is not the duty of the doctor to give information of his patient's condition. If such breach of secrecy were right and proper, it ought to be openly authorized by the rules of the medical profession, since otherwise a medical man, when incurring serious risk from a sense of duty, is prejudiced by an apparent breach of faith to his patient,

who would certainly regard it as such. The objections to any refusal to observe secrecy in cases of the kind render it altogether inadvisable. If a medical adviser is justified in divulging the fact that a patient has syphilis, why should he not give information when a patient is about to marry who would in his opinion not be likely to have healthy children, or is a drunkard, or otherwise objectionable?

In Cases of Criminal Conduct—It not infrequently comes to the knowledge of a medical man, in his practice, that a patient has been guilty of criminal conduct, and it might be contended that he becomes to some degree an accessory if he fails to give information to the police. Called to attend a patient suffering from the results of criminally procured abortion, it may be said that secrecy on the part of the medical attendant tends to the encouragement of this offence, but so, to some extent, does his success in mitigating the consequent illness of the patient. If the doctor could not be trusted, the patient would try to deceive him, notwithstanding the grave danger to herself if she succeeded. In fact, cases do occur in which this happens even in present circumstances. It is justifiable, although not a definite duty, to urge the patient to give evidence voluntarily against a person who has procured abortion for her, but, without her free intelligent consent, her medical attendant should not betray the confidence reposed in him in order to check criminal practices of the kind.

In the Case of Death, the law does not permit secrecy, and it cannot be maintained. Even then it not uncommonly will happen that legal proof of criminal abortion will be wanting, and resentment will be aroused against the doctor, for bringing discredit upon his deceased patient. Where death has not occurred a statement that abortion had been criminally induced, if not capable of strict legal proof, might involve the doctor in an action for damages for slander, or libel, and such action, if successful, would, in view of the betrayal of confidence, probably entail vindictive damages.

The only circumstances in which any violation of the rule of secrecy should be contemplated are those which may

discussed with the patient, who should be advised to do what is right under the circumstances. Information should in no case be given to the mistress, or anyone else, without the patient's free consent, and care should be taken that proof of such consent is available, if it is acted on. In the case of lunatics, or children, information such as is needed for the proper care of a patient should be given to the persons in charge.

PROFESSIONAL SECRETS IN THE WITNESS-BOX

It is to be regretted that the law in this country does not forbid a medical attendant to betray professional secrets in the witness-box. It is not sufficient that he should be at liberty to refuse to do so if he chooses, because optional refusal to give evidence may be regarded as implying that there was something which the patient wished to conceal, and it might consequently be prejudicial. In the present state of the law a medical man cannot be expected to expose himself to possible penalties by refusing to give evidence in violation of professional confidence when directed to do so by a judge, but there is always great professional support of such refusal in suitable cases. If a firm stand were taken by the medical profession in the matter, it is unlikely that any prolonged conflict would be required to establish in the law courts a recognition of the duty of medical secrecy.

It is the patients, and not their medical advisers, who would derive advantage from the prevention of the revelation of medical secrets in the witness-box. To patients suffering from many diseases it may be ruinous if their condition is made public to the world by the extracting of information on the subject from their doctors in the witness-box. The dread of such a disaster undoubtedly affords an opportunity for blackmailing without resorting to any criminal procedure. The unwilling medical witness is a common feature of divorce proceedings, since his evidence will often do irreparable injury to the reputation of the patient. It seems strange that the public allow

themselves to be constantly victimized in this way when they have full power to put a stop to it. But a medical man is much less likely to be subpoenaed as a witness if it is quite unknown to the solicitors concerned what his evidence will be, and it is sometimes his own fault when they are aware of it beforehand.

The matter of medical evidence is discussed in Chapter XXII

CHAPTER XI

PANEL PRACTICE

Application for Admission to Service—Conditions of Service and Duties—Payment and Goodwill—The Controlling Authorities—Urban and Rural Needs—Lock-up Surgeries—Panel Prescribing—Checking and Controlling Extravagance—Personal Variations and Excessive Prescribing—A Note on the Administration of Anæsthetics

MUCH can be said for or against any system of compulsory health insurance controlled by the State, and there is still greater scope for argument when considering the particular system which was established in this country in 1911 under the National Health Insurance Act. With the merits or demerits of that system we are not here concerned. For the purpose of our present subject it is sufficient to stress the fact that there are to-day probably 15,000,000 people in this country who are compulsorily insured, and who, with few exceptions, seek and obtain their medical attendance and treatment only from panel medical officers.

This figure would, by itself, indicate that the treatment of insured persons is a matter which the average doctor about to start in general practice cannot afford to disregard. But the influence of national insurance extends farther. The normal family does not employ two medical men. Even in these days of revolutionary tendencies, the "family doctor" remains a very real and popular conception. There may be only one insured person in a family of four or five, yet the "panel doctor" who is chosen to look after him will almost invariably be sought when the non-insured members fall ill. Whether for good or for evil, the doctor who is starting in practice will, with rare exceptions, be virtually compelled to choose between undertaking insurance practice or being satisfied with a greatly restricted private practice. It is not surprising, therefore, that there are

now probably 15,000 panel doctors in the British Isles, and that this number is increasing

PRELIMINARY STEPS

In the administration of medical benefit under the National Insurance Acts the controlling authority does not, as in the case of most other public health services, select the doctors by whom the service is to be carried out. Every qualified medical practitioner—that is to say, every doctor whose name appears on the Medical Register—is entitled as of right to treat insured persons. Moreover, the insurance practice cannot be terminated without the consent of the doctor except for some very grave offence, and then only after a special inquiry by the Minister of Health.

The method of entering insurance practice is simple. For the purpose of administering medical benefit, public bodies, known as insurance committees, are set up for each county and for the larger county boroughs. The members of these committees represent insured persons, doctors, chemists and the local council. One of the obvious duties of the committee is to arrange for the necessary supply of doctors, and for this purpose it keeps a list of the names and addresses of the local practitioners who have undertaken to treat insured persons. This is the “panel”—officially known as the Medical List. A doctor undertaking insurance practice must first secure that his name is included on this list. To do this it is necessary only to send to the clerk of the insurance committee (whose address can be obtained from any post office) the following notice

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service under those terms and apply for admission to the medical list of the Committee

The district or districts within which I undertake to visit insured patients and particulars of my surgery hours are given below —

District	Surgery	Days and Hours of Attendance	Signed	Date
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On receipt of this notice by the insurance committee, the doctor's name (assuming that it does, in fact, appear on the Medical Register) must be entered on the Medical List for the district, and the doctor thus becomes entitled to treat the insured persons who may apply to him. In practice, the clerk to the committee informs the doctor that his name has been placed on the list, and also furnishes him with a supply of the many forms which appear still to be inseparable from any State-controlled service—e.g. certificates, record cards and prescription forms

CONDITIONS OF SERVICE AND DUTIES REQUIRED

Concurrently with the doctor's right to treat insured persons, there necessarily arise the duties and obligations which form part of the doctor's agreement with the committee. Before 1920 the doctor signed a contract which specified many of these obligations. Now there is no written form of contract, but the contractual relationship remains. It will be observed that the notice states that the doctor desires to treat insured persons "upon the terms for the time being in operation". These terms are mainly set out in the Medical Benefit Regulations, 1924. So far as the provisions of those regulations affect his insurance practice, the doctor is bound by them—they form part of his "contract". The part of the regulations most directly affecting the doctor (Schedule I, which includes the "terms of Service" and the Medical Certification Rules) is issued by the insurance committee as a separate document. There are also two schemes prepared by the committee: one, known as the Allocation Scheme, applies the general requirements of the regulations on such matters as the provision of emergency treatment and the limitation of panel lists,

the other—the Distribution Scheme—deals chiefly with remuneration

It should be understood that when a doctor notifies the insurance committee that he wishes to treat insured persons, he thereby accepts the terms of service set out in the regulations and in the two schemes. He should, therefore, obtain copies of these documents from the insurance committee and should inform himself of their provisions before sending in his formal notice.

The principal services which the doctor undertakes to give to insurance patients may be summarized in general terms as follows

- 1 The provision of general practitioner treatment to all insured persons on his list, excluding treatment in respect of confinements or attendance at miscarriages, but including the administration of anaesthetics or the provision of an anaesthetist (see p 102)

- 2 The provision of emergency treatment to any insured person whose doctor is not, at the time, available

- 3 The writing of prescriptions for necessary medicines and certain appliances on a special prescription form. In some cases the doctor must himself supply the medicines or appliances, at an additional rate of payment

- 4 The issue of certificates. In all, there are five certificates of incapacity, one death certificate, and one voluntary certificate (see Chap XII)

- 5 The keeping of records in respect of the diseases and treatment of all his insurance patients

The doctor undertakes to visit any patient whose condition requires it, and to provide proper and sufficient surgery accommodation for those patients who are well enough to attend at the surgery.

The insured person, on his side, is bound by rules which, among other things, require him to obey the instructions of his doctor, not to make unreasonable demands upon his professional services, and not to summon him during the night except in cases of serious emergency.

PAYMENT AND GOODWILL

Except in Manchester and Salford, where until 1926-27 an attendance system prevailed, payment for insurance practice

is made on the capitation basis. A Court of Inquiry which was appointed by the Minister fixed the capitation fee for 1924 at 9s, and recommended that this fee should continue until the end of 1927. It should be understood that under the capitation system of payment the Central Fund from which all payments are made is constituted by multiplying the capitation fee of 9s by an estimated number of insured persons in the country. The Central Fund is then distributed among the insurance committees according to the number of insured persons calculated to be in each area by reference to the local committee's register. As the local registers do not provide a true count of the number of insured persons actually in the area at any given time, the doctor will not necessarily receive an amount exactly equivalent to the sum of the capitation fee multiplied by the number of insured persons on his list. Payment is made quarterly. Generally speaking, a doctor is not permitted to accept any fee from an insurance patient.

In addition to the flat rate per head of insured persons on the doctor's list, there are certain special payments—e.g. in respect of anæsthetists' services and the treatment of temporary residents. Where a doctor is required himself to supply drugs and appliances, he receives an additional payment of 2s 3d a head, with special payment for certain expensive drugs and appliances, as vaccines and insulin. Doctors in the rural areas also receive a "mileage allowance" where the patient resides more than two miles away, or where the country presents special difficulties of travel.

In considering the income to be derived from panel practice it must be remembered that, except under very special conditions, a doctor in single-handed practice is not allowed to have more than 2,500 insured persons on his list. If assistants are employed he may be permitted to have an additional number, not exceeding 1,500 for each assistant. Partners must not have more than an average of 2,500, although any one partner may have up to 3,000.

The power of business organization displayed either by a single-handed doctor or by a firm varies indefinitely, so

that the ability to deal fairly with any particular number of patients will also vary, accordingly in some cases the needs of the area, when quite a large one, are always well covered and the response to demands prompt, while in another area, not necessarily larger, neither of these things happens. Public complaints follow which for the most part would never have occurred had the day-by-day conduct of practice been more orderly. There are, however, many districts in this country, without reference to the Highlands and islands of Scotland, where special arrangements have been necessary, in which practitioners must necessarily be few compared to the area to be covered, and where doctors have to spend excessive time in travel for domiciliary work, and where the same disability meets patients having recourse to the surgery. This position has been met in certain places by the institution of lock-up surgeries, and the working of them is made the subject of a note later, as positions may arise under the system which are prejudicial to the public and derogatory to the methods of medical practice.

Goodwill in an insurance practice has never been officially recognized, although the principles are now largely the same as with private practice. A doctor buying a practice which includes a panel of insured persons cannot, of course, buy the right to treat all the insured persons who were on his predecessor's list, for every insured person is now able to change his doctor at any time. The regulations do, however, provide that the doctor who withdraws from the Medical List of an area may require the insurance committee to notify his insurance patients that his successor is willing to accept them on his list, and the incoming doctor receives for a limited period extra payment in respect of this undertaking to accept any of his predecessor's patients.

THE CONTROLLING AUTHORITIES

The general relationship of the insurance doctor to the various bodies concerned in the administration of medical benefit may be indicated, if only briefly. The Approved Societies, as such, have no control. They are concerned primarily

with the payment of cash benefits, and they may therefore be brought into contact with the doctor on questions of certification of incapacity, but not even on such matters have they any power directly to control the doctor's work. Indirectly, however, the societies, as representing insured persons, nominate three-fifths of the members of the insurance committee. The insurance committee is the body which deals with the practical administration of medical benefit. It is with this committee that the doctor enters into his agreement, and it is this body which will, in the first instance, investigate any complaints made by or against him. The committee also distributes the remuneration. Even this committee cannot, however, alter the doctor's terms of service without the express consent of the Minister of Health.

On all important matters the Minister of Health determines the conditions of insurance practice, and it is with him that the Insurance Acts Committee of the British Medical Association hold the consultations which, in practice, have always preceded any material alteration in the terms of service. The doctor has a right of appeal to the Minister from any disciplinary decision of the insurance committee, only the Minister can alter the rate of remuneration or inflict a pecuniary penalty. The Minister has appointed regional medical officers throughout the country. In addition to their specific duties as referees, these officers are in a position to offer general advice and guidance, and it is to the advantage of a doctor entering into insurance practice to become acquainted with the regional officer for his district.

Finally, there is in each area a panel committee which is a body directly representative of insurance doctors. All the members are doctors and three-fourths are panel doctors. It may be said, generally, that the panel committee must be consulted by the insurance committee on all matters (e.g. the alteration in the terms of service) which materially affect the insurance doctor. The panel committee is also a body which can be consulted by the individual doctor on

any matter of doubt, more particularly when the opinion of the profession rather than the official view is desired

URBAN AND RURAL NEEDS "LOCK-UP" SURGERIES

The system of medical attendance and treatment under the National Health Insurance Acts has of recent years brought prominently before public notice the question of the provision of what are generally known as "lock-up" surgeries. Of course, the use by medical practitioners of these "lock-up" or "branch" surgeries prevailed long before the Insurance Acts were thought of. They owed their origin primarily to the recognition by practitioners of the desirability of providing facilities whereby their personal services could, at specific times in the day or at call, be brought nearer to the homes of their patients.

Rural Needs

In the case of sparsely populated and extensive rural areas, where the inhabitants live in villages and isolated hamlets, there is no doubt whatever that the existence of a lock-up or branch surgery has been, and is still, a necessity, and can be said to furnish the only satisfactory arrangement. Resident medical practitioners must necessarily be few and far between in such areas, and those who use the surgeries have to spend much time in travel from their homes to their patients. They must, of course, reside as near as possible to the centre of their practices so as to render themselves more readily available day and night to the greater number of their patients. Consequently some form of non-residential provision for the more distant areas of these practices becomes essential. This applies with equal force to the private and insurance sides of general medical practice.

With the present-day extension of the telephone service, communication between such surgeries and the doctors' private houses has become much easier. Delay in establishing communication with a practitioner in emergency must inevitably result in danger to the patient and dissatisfaction

to the doctor himself. A practitioner having voluntarily established a lock-up or branch surgery imposes upon himself, therefore, the moral obligation to provide adequate attendance and treatment thereat and therefrom. While, it is conceivable that the establishment of a lock-up or branch surgery in or near an outlying village would reduce unduly the extent of the practice available to a doctor resident in that village, with the consequent risk of making it impossible for the resident practitioner to derive an adequate living from the remaining portion of the population, nevertheless action for the prohibition of such an establishment should not be lightly undertaken, because it might tend to restrict in some degree free choice of practitioner by patients, and also to militate against the best interests of the medical service of the area generally.

This phase of the subject is recognized in National Health Insurance practice, as is evident from the following reference thereto in the mileage schemes adopted by some insurance committees

Provided that, in cases where the practitioner (or any partner of his) has a surgery which is nearer to another practitioner's residence than it is to his own, the credit (i.e. for mileage grant) shall be based on the distance from that surgery to the residence of the insured person

In other words, this means that if practitioners in rural areas open lock-up or branch surgeries in outlying districts where other practitioners reside, they cannot always expect to receive credits for mileage measured from their own residences to the homes of patients residing within the vicinity of such surgeries

Urban Needs

In the case of more thickly populated urban areas and towns the need for the lock-up surgery system is not so apparent, at least from the point of view of the public. Generally speaking, the residences of practitioners in such areas are so placed as to be within a mile or so of their farthest patients, and the number of practitioners resident

within a small area is much greater. The incentive to establish a lock-up surgery in such an area cannot, therefore, be regarded on the same plane as in the case of rural practice. Here the convenience of the patients does not appear to be the primary consideration. Extension of practice, the desire for improved residential environment, the dearth of residential accommodation in building up a new practice—these would appear to be the governing factors.

Now while the desire to extend a practice is quite legitimate in its way, it should not be permitted to dominate the best interests of the patients needing advice and treatment and of the other practitioners resident in the district. But the wish for improved residential surroundings, especially in a number of areas of this country, is perfectly comprehensible. The extraordinary thing is that some of the urban areas should enjoy a resident practitioner at all. Persons with the nurture and training of a physician need considerable courage in addition to their other gifts in order to spend the best years of their lives in the squalid surroundings presented by some of these districts. The prospect for the wife and family of such a practitioner is far from alluring. The charge has been levied that, the Insurance Acts having provided a well-assured income in respect of the treatment of the poorer classes, practitioners and their families have migrated to more salubrious surroundings during their hours of rest and recreation. If there were any truth in this charge the difficulty has been well met by the action of the responsible authorities under powers conferred by the provisions dealing with surgery accommodation in the Medical Benefit Regulations. Yet, granting the conditions of some of our town areas, practitioners can hardly be blamed for taking the earliest opportunity of improving their lot in respect of living accommodation and environment.

Drawbacks and Safeguards

The establishment of a lock-up surgery by a medical man or woman commencing practice in an urban or town district is, however, least worthy of approval at the present time,

notwithstanding the prevailing shortage of housing accommodation, and should not be recognized for insurance purposes unless the practitioner lives within easy distance of the surgery provided, and unless his services at and from the surgery are as readily available at all times as they would be if it were situated at his place of permanent residence

Whatever the motive for the inauguration of a lock-up surgery may be, and whether it be intended for the use of private patients or insured persons, such an establishment cannot serve the best interests of either the medical profession or of the sick public, unless adequate facilities are provided thereat for calls upon the practitioner's service at any time of the day or night by the employment of a caretaker and the provision of a telephone. Efficient safeguards must also be effected against the possibility of the other practitioners resident in the district being burdened unduly with the absent practitioner's responsibilities

Some of the less friendly critics of the State insurance medical service have, from time to time, pointed to lock-up surgeries as evidence of the alleged unsatisfactory provision made for the medical needs of the insured members of the community. In a few cases such criticism may be justified in relation to a very small number of insured persons, but no sweeping indictment of the service on this account can be substantiated. It may truthfully be said that the establishment of the service has rendered obligatory upon all the contracting practitioners the provision of many of the good features which existed in well-conducted private practices in pre-insurance days. With the passage of time the administrators of the Act have had opportunities for comparison, from which has resulted the endeavour gradually to raise by legislation the standard in every direction, including surgery accommodation

In the last issue of the terms and conditions of insurance medical service it is laid down that a practitioner is required to provide proper and sufficient surgery and waiting-room accommodation for his patients, having regard to the circumstances of his practice. The form of words used here

is very wide in its application and embraces the obligation to provide, if necessary, a lock-up or branch surgery, equally with the abandonment of such a surgery if, in the opinion of the authorities, circumstances demand it. It is known that some practitioners own branch surgeries which they work wholly through permanent assistants. Rarely, if ever, do they put in an appearance or answer calls from patients accustomed to use such surgeries in the belief that their treatment is under the supervision of the principals whose names appear on the door-plates. These may be characterized as among the worst forms of lock-up surgeries and might well, in certain conditions, give rise to the suggestion of practising under misrepresentation.

PANEL PRESCRIBING

The provision of medicines for panel patients has given rise to much bona-fide misunderstanding and to much malicious misrepresentation. The doctor and the insured person have been equally concerned. There is a psychological reason for the patient's suspicion. The "bottle of medicine" still remains a popular, an almost sacrosanct institution. Medical treatment without it is regarded as, either mean, inefficient or neglectful. Health education has not yet persuaded the commonalty to accept without resentment a treatment of self-denial as a substitute for an intemperate indulgence in physic. Anything which tends to depreciate the contents of the medicine-bottle is, therefore, a factor of great influence on the minds of the insured population.

The widespread misconceptions on the part of many insurance doctors is also explicable. The varying provisions of statute and regulations, and the varying practices at one time current in different areas, have no doubt had much to do with them, but the trouble mainly centres in the novel method of control which the regulations have set up in connexion with what is felt by so many doctors to be essentially a matter for private professional judgment.

The following does not apply to doctors who themselves

supply drugs and appliances at a capitation rate—their main concern is as to the adequacy of the capitation rate. Reference is made only to medicines, but the principles apply equally to the ordering of such appliances as have been prescribed by regulation.

Basic Definitions

There are three fundamental definitions. Section 8 of the National Insurance Act, 1911, defines medical benefit as “medical treatment and attendance including *the provision of proper and sufficient medicines*.” This definition is amplified by the medical benefit regulations. Schedule I includes among the insurance doctor’s duties the prescribing of “*such drugs as are requisite for the treatment of any patient*,” while Section 37 (dealing with excessive prescribing) sets up, as the standard of character and quantity of the medicines, “*what is reasonably necessary for the adequate treatment*” of the insured person.

It is of the first importance that these definitions should be kept clearly before the mind. They are the authoritative statutory definitions to which the doctor can appeal, any departmental decision and any administrative or executive action on the part either of the Central Department or of the local committees which did not accord with them would be *ultra vires* and could be successfully contested in a court of law. In fact, however, the Ministry of Health does not appear to have attempted to limit improperly the scope of these definitions or to restrict unduly the professional judgment of the doctor in applying them. Emphasis has repeatedly been given to the principle that the doctor is not only entitled but required to prescribe the medicines—whatever may be their cost—which are, in fact, necessary for the proper and adequate treatment of the patient. On a broad view of the question it could not be otherwise. One has only to consider the list of drugs and appliances for which special payment is made to doctors who themselves supply medicines at a capitation rate. The list includes vaccines, serums, peptone and glandular preparations, and

insulin It is not reasonable to suppose that a scheme, which admittedly allows the provision of these preparations whenever they are actually necessary for the treatment of the patient, should require or encourage the doctor to deny other and cheaper necessary medicines

Checking Extravagance

The misunderstandings are traceable to the provisions of the regulations for dealing with cases of "excessive prescribing" The whole principle of control in this respect, and the detailed machinery which has been set up to secure that control, are criticized on three grounds (1) that the rules are unnecessary, (2) that they constitute an unjustifiable and improper interference with the doctor's professional judgment, (3) that the mere possibility of surcharge constitutes, in effect, a continual menace which has justified the belief in an unduly restricted choice of medicines for insured persons

In considering whether there is a need for any sort of check or control, it must be recalled that we are dealing with a scheme of insurance No insurance policy can offer unlimited benefits for limited premiums, the defined premium covers a defined risk The premiums on the National Health Insurance "policy" cover, among other things, the provision of whatever medicines are reasonably necessary for the adequate medical treatment of the policy holder—i.e. the insured person This is clearly something different from an unlimited supply of medicines or medical preparations, irrespective of their actual need for treating the particular illness A Judge of the High Court has thus interpreted the position

The Act is worked upon a scheme that there is to be a fund to provide for these drugs as well as to pay the doctors, and it is obvious that there is a limit to the amount available for that purpose The duty of prescribing for any patient necessarily involves that the prescription must be reasonable according to the resources available for pay there must be a duty on a panel doctor not to be extravagant or reckless in ordering medicines which are unnecessarily expensive

That is to say that the doctor must prescribe for his insured patients whatever drugs are necessary for adequate treatment, however costly they may be, but on the other hand, he must have due regard to cost and not order the more expensive preparations for purposes for which the less expensive will serve equally well

Accepting this necessary limitation to the benefit provided, some sort of control would seem to be unavoidable. The insurance scheme affects 15 million persons, for England alone 36 million prescriptions are now written in the course of a year at a cost of close on 1½ million pounds, and the number is steadily increasing, some 15,000 doctors are entitled by writing prescriptions to make heavy charges on the insurance funds without affecting their own remuneration. If the actuarial calculations underlying the insurance scheme are to be verified, some check must evidently be put upon the giving of benefits which are not covered by the prescribed premiums

The Machinery of Control

Granting the need for some form of control, does the existing machinery involve undue lay interference with the professional judgment of the doctor? All National Health Insurance prescriptions are priced at the Pricing Bureaus which have been set up at various centres. In the course of this work certain tables of averages are prepared, affecting the lists of individual doctors, or given areas. These figures are submitted for scrutiny to the Minister of Health. If the scrutiny reveals in the case of an individual doctor an average cost per prescription considerably in excess of the general figure for the area, further details as to the individual prescriptions affected are obtained from the bureau. If this further information still suggests an unexplained and considerable excess above the average, the Ministry takes initial action by bringing to the doctor's notice, through the regional medical officer, the facts which suggest extravagant prescribing. The doctor can then either make an oral explanation to his regional medical officer (who will call

upon him—accompanied by a representative of the panel committee, if that committee so desire) or he can send a written reply direct to the Minister. Often the matter will not go beyond this stage. If the *prima facie* case of extravagance seems to require more formal investigation the whole matter is referred to the panel committee—a body, be it remembered, consisting solely of doctors, at least three-fourths of whom are panel doctors. It rests with the panel committee alone to decide the crucial question whether there has or has not been extravagance, and before that committee can arrive at this decision they must give the doctor an opportunity of appearing before them or of submitting a statement. The subsequent functions of the insurance committee and of the Minister are respectively to recommend and decide the penalty, if any, to be inflicted, if the panel committee finds that there has, in fact, been extravagance. The doctor may appeal against the panel committee's decision to a court of independent referees of whom one must be a doctor, the Minister can similarly refer the case to independent arbitrators if he is not satisfied with the action of the panel committee. Further, the Minister may permit a panel committee to make the initial investigations of statistics on which the *prima facie* case is established.

The essential decision as to whether there has been extravagance is thus in the hands of the panel committee or of an independent court of referees on which the profession is represented. So far as there is interference with the professional judgment of the doctor it appears to be an interference sanctioned by members of his own profession.

Personal Variations

The general opinion or practice of the profession does not, however, necessarily determine the question, for it has on several occasions been recognized that the personal element in prescribing is a material consideration. The following official dicta may be quoted

In interpreting the term "reasonably necessary" allowance must be made for the personal element. It is clear that if insurance practitioners are to retain the independence of judgment that is necessary for the best treatment of their insured patients, rigorous conformity with the view of the majority of the profession or of a Committee of the profession must not be required of them, and, that the progress of medical science may not be checked, scope must be allowed for the exercise of initiative and for suitable experiment. The enforcement of stereotyped methods and standards of prescribing would be prejudicial both to the immediate interests of patients under treatment and to the ultimate interest of insured persons generally.

Just as one workman can use a tool better with a handle of one shape and another with another, so it is desirable that, within reasonable limits, a doctor should be allowed to follow methods of treatment which are most congenial to him.

The question is not to be determined by the test of rigid formulæ, but by the application of common sense to the facts of the particular case, which must be viewed as a whole.

Similarly, consideration is given to the particular circumstances of the practice. Thus, the average cost per prescription will probably be greater in the small practice. Or again

If the patients of a practitioner considered collectively require a more than usual amount of treatment, or are particularly liable to illnesses requiring treatment of a more than ordinarily expensive kind, or if he has a run of cases of a particular kind requiring specially expensive treatment, all these facts must be taken into account in interpreting the meaning of a high average cost of prescribing.

On the other hand, it has been established that the adoption by the doctor of similar methods of prescribing for private patients does not in itself afford proof that there has been no extravagance as regards panel patients. Neither is the preference of the patient for a particular medicine regarded as providing in itself a sufficient ground for relieving the doctor of the responsibility to decide what is necessary.

Excessive Prescribing

There remains the criticism, undoubtedly of considerable influence, that the mere existence of an elaborate machinery for penalizing excessive prescribing places an undue restraint on the writing of prescriptions. A brief survey of the main principles on which cases referred to the Minister have been

determined may assist in assessing the measure of apprehension which is justified

One group of cases deals with an unnecessarily high cost of the medicine or of some of its ingredients. This may occur through the unnecessary use of patent medicines or proprietary preparations where an equally efficacious but less expensive B P preparation is available. But proprietary preparations are not, as a class, disallowed, since proper allowance for the needs of exceptional cases might justify the use of a proprietary article in a certain number of cases. The question to be determined is whether it was necessary for the adequate treatment of the patient that preparations made by particular manufacturing firms should be used instead of less expensive preparations suggested in the B P which are ordinarily employed by medical practitioners for the same purpose.

The question of unnecessarily expensive B P preparations is governed by the same considerations. Where, through a routine prescription of particular combinations or mere indifference, costly ingredients are included without improving the therapeutic value of the medicine with reference to the particular patient for whom it is prescribed, a legitimate case for criticism would seem to lie. Thus an excessive use of flavouring agents may constitute extravagance.

Instances have arisen where an expensive medicine is prescribed on the recommendation of a consultant. Here the view of the Ministry is that the consultant's recommendation is clearly a matter of which account must be taken in determining whether the medicine was reasonably necessary, although obviously extravagant prescriptions could not be justified solely by reference to the consultant's advice. Cases have, again, occurred where an unnecessarily high dispensing fee has been incurred. The unnecessary prescription of a preparation in powder or tablet form has, for example, been held to place an unjustifiable charge on the drug fund.

Finally, there is extravagance by unnecessary frequency

of prescriptions Here again, so far as recorded cases go, the abuse has ordinarily been obvious where a penalty has been inflicted

The Position Summarized

It seems that the cases where surcharge has been upheld by the Ministry are, generally speaking, not such as would regularly occur in the practice of the reasonably careful practitioner, neither do they appear to afford ground for undue apprehension or for an excessive caution in withholding medicines from insurance patients The subject has been so overlaid with misunderstanding that an exaggerated complexity has been attributed to it So far as the doctor is concerned, there seems to be only one standard and one question to be answered "Is the medicine or preparation which I propose to prescribe reasonably necessary, as regards character and quantity, for the adequate treatment of the particular patient for whom it is to be prescribed?" If the answer is in the affirmative, the statute and regulations definitely sanction the prescription It may be said that this is not an easy standard to apply But is it not, after all, precisely the standard which is daily applied by the many doctors who are supplying medicines at a capitation rate of payment?

A NOTE ON THE ADMINISTRATION OF ANÆSTHETICS

The first undertaking which the panel practitioner gives to insured patients is to provide "general practitioner treatment including the administration of anæsthetics or the provision of an anæsthetist" The administration of anæsthetics is the one form of special work which calls for particular attention, because every doctor is in intimate connexion with it daily without being necessarily an expert, and because responsibility here is entailed by Act of Parliament on the panel practitioner, although he is not presumed to possess any special or expert knowledge The position is he administers the anæsthetic or provides the anæsthetist as a duty under the National Insurance Act,

and a fee for the service can only be charged when the administration is connected with an operation which is one not contemplated by the terms of the service. This situation implies the referring of the particular case to an operating surgeon, by whom the anæsthetist would be chosen, the practitioner, of course, being present at the operation if he chooses. Here fees are provided to meet the expert service, and if the actual administration of the anæsthetic is itself the work of an expert, similar provision is made. The anæsthetist would then be considered to have been called in to perform a duty outside the scope of panel practice, and therefore the work has to be paid for as an accessory.

Apart, however, from such particular connexion of the administration of anæsthetics with panel practice, points arise which must be borne in mind by all practitioners. They are mentioned here because those points are also the ones which the panel practitioner, with a statutory duty to discharge, should also have in his mind when deciding that the administration of an anæsthetic in a given case does not fall under the heading of "general practitioner treatment." Speaking generally, considerations of treatment are outside the scope of chapters dealing with the conduct of practice, but at this point the therapeutic course to be pursued has to be taken into consideration when deciding how an Act of Parliament should be construed in the public interest.

Certain Risks in Administration

Theoretically, and in law, the qualified medical man, however recent his registration, is competent to give anæsthetics in any circumstances. Actually, most practitioners have had but limited opportunities of gaining full experience in their student days, and many occasions may arise in their later work when it is not only expedient but even essential for the patient's safety that the task should be relegated to a really experienced man. When circumstances allow, this is usually done, but an emergency may, of course, be so acute that there is no room for deliberation.

In the vast majority of instances, however, when there is time to provide a special surgeon, there is also time to procure an anæsthetist

Apart from emergencies, the practitioner without special experience is wise if, generally speaking, he does not undertake the administration in (1) abdominal operations, (2) operations involving the air passages. In the latter class the operation for removal of tonsils and adenoids may be mentioned, where the operation may not be considered to demand the aid of an operating surgeon, when the administration of the anæsthetic comes also to be regarded as a fitting opportunity for the non-expert, in its modern form the operation is one that requires, almost more than any other, special knowledge on the part of the anæsthetist if accidents are to be avoided

Perhaps the most dangerous emergency operations for which the practitioner might be tempted to give a hurried anæsthetic, and in which he should certainly avoid the responsibility unless he has special experience, are (1) operations for the relief of acute cellulitis of the neck (Ludwig's angina) and (2) operations for relief of strangulated hernia which has been in existence some time and is accompanied by frequent vomiting. The subjects of Ludwig's angina commonly have some oedema of the glottis and acute obstructive asphyxia is liable to supervene if the anæsthetic is not correctly chosen and skilfully administered. Nitrous oxide is especially dangerous for these patients. In the strangulated hernia cases fatal inhalation of the thin black material, which is quietly regurgitated into the pharynx, is only to be avoided by special measures

A minor operation in which the anæsthetic risk is commonly underrated, and which yearly contributes to the list of deaths during anæsthesia, is that of circumcision in infants. Infants are, as a matter of fact, the most difficult class of human subjects in whom to realize accurately the degree of narcosis that has been obtained. In addition, owing to the uncontrolled activity of the reflex system in early life,

they are prone to exhibit movements during stages of anæsthesia which would ensure quiet in older subjects. Consequently the inexperienced administrator is easily led to dangerous overdosing of infant subjects if he relies on the anæsthetic for absolute immobility during operation. No such complete immobility of the lower limbs by means of the anæsthetic should be aimed at during the circumcision of infants, but the thighs being firmly held against the table, a light, safe, open ether anæsthesia provides perfect facility for the operator and, of course, complete immunity from sensation on the part of the patient.

Attendance on confinements is not included in the terms of panel service, but, of course, the bulk of obstetric practice is carried on by panel practitioners, called in either in the first instance or by a registered midwife in accordance with her statutory obligations. The administration of anæsthetics during labour is commonly regarded as the least risky of procedures. It is, of course, true that for a variety of reasons the woman in labour is exceptionally favourably disposed towards narcosis, but nevertheless accidents are not so rare as is often supposed, and the practitioner's activity should be based on sound principles. Very often he is called on to manage both the labour and the anæsthetic with the help only of a nurse or a registered midwife. In a normal labour this task can be safely accomplished, for the nurse, if given the management of an anæsthetic, as she probably will be, during the critical passage of the head per the perineum, will have been admonished to use the anæsthetic in the most sparing manner. If, for example, chloroform is being applied from a drop-bottle on a towel or a mask the nurse will not be allowed to let the latter actually touch the patient's face. If the labour is not normal, and the application of forceps or some more formidable operation is required, the practitioner should always entrust the anæsthetic to a qualified colleague. Full surgical anæsthesia is necessary. It should not be obtained by chloroform alone, and if that form of anæsthesia is resorted to at the hands of a nurse or mid-

wife, disaster is not only possible but probable. In panel practice it is well to remember that, although for those operations within his own terms of service the practitioner provides the anaesthetist as a duty and without fee, yet when he regards the administration as the work of an expert he can call in an expert anaesthetist, who will be paid just as is any other expert, called in to perform operations outside the scope of panel service.

Some Necessary Precautions

As regards administering anaesthetics to women, apart altogether from the question of labour, the practitioner should make it an absolute rule never to procure narcosis without the presence of a third person. This rule is especially important when nitrous oxide is the agent to be employed, for during the narcosis thus produced erotic dreams are common, and are easily misinterpreted by the semi-conscious subject into impressions of misconduct on the part of the administrator.

A possible source of vexatious litigation in connexion with anaesthetics has often been revealed by the occurrence of minor but avoidable injuries. In this category come burning of the skin of the face, damage by a hot gag, injury to the eyes, and posture paralysis from pressure on nerves during anaesthesia. Injury to the eyes, generally slight and transient but sometimes amounting to actual corneal ulceration, is very common. It is best avoided by devoting special care to keeping the eyelids carefully closed during operation, and by consulting the eye very little by inspection, and still less by the finger. The practitioner must bear in mind that nowadays full responsibility for the anaesthetic, both at the operation and in its after-effects, rests with the administrator. The surgeon is responsible only for choosing a competent anaesthetist. When the general practitioner gives the anaesthetic with the surgeon's consent, the surgeon has admitted the practitioner's competence and relegated to him full responsibility in the matter.

CHAPTER XII

CERTIFICATION OF PANEL PATIENTS

*The Question of Incapacity—Irregularities in Certification
“Obliging the Patient”—Handy Certificate Books—Pressure
by Societies Difficulties of Diagnosis*

THE writing of certificates is among the most criticized of the many duties of the insurance practitioner, who contends that the certification rules are quite unnecessarily complicated and onerous. The case prepared by the Insurance Acts Committee for consideration at a public inquiry went so far as to describe them as “oppressive and menacing,” and expressed the view that they were not designed to secure to the insured person the sickness benefit properly due to him, but rather required the doctor to perform a service to the Approved Society under a threat of penalty. This expression of opinion is significant, because in no other respect did the profession complain that the panel doctor’s duties are unnecessarily burdensome. The Approved Societies, on their side, allege that their funds suffer serious loss through loose and irregular certification.

Certification has necessarily a very real bearing on the whole financial structure of the national insurance scheme. Out of the total £22 million spent on benefits in England and Wales in 1922, more than £11½ million was for sickness and disablement benefit, and represented cash paid out to individual insured persons on the evidence of the doctor’s certificate. This financial aspect was recognized by the Government in 1913 when a Departmental Committee was set up to report on the sickness benefit claims. The outcome was the appointment in 1920 of the regional medical officers, R M O, whose principal duty it was to act as referees to settle doubtful or disputed cases of incapacity. The number of references to these officers increases each year. The

total references for England during the three years 1923, 1924 and 1925 were 134,514, 168,423 and 183,647 respectively. Of the 1925 cases, the R M O decided in 24,112, i.e. 13 per cent, that the patient was capable of work, while in 44 per cent of the cases the patients failed to attend for examination, including those, about one-half, in which the patient had meanwhile been certified as fit. The recent figures are much worse, the industrial crisis following the coal strike leading to heavy sickness benefit, and expostulation on the part of the societies. These figures do not necessarily connote widespread carelessness or wilful irregularity, they do suggest that health insurance certification is not yet fully satisfactory, and in particular that considerable difference of opinion exists as to the circumstances which justify the conclusion that a patient is incapable of work.

THE QUESTION OF INCAPACITY

The certification of incapacity may present considerable difficulties. No definition of "incapable of work" has been officially issued, while no administrative decision or financial consideration should materially limit the professional judgment of the doctor. Cases arise where the question is not solely medical. Where the illness is one from which the patient is likely to recover within a reasonably short period, the only consideration is whether, for the time, he is capable of following his normal occupation or employment. Where, however, the illness is protracted or chronic, the question will, at some stage, arise as to whether the patient, although still incapable of following his previous occupation, is able to undertake some other remunerative work.

The latter question, it may be argued, is one on which it is scarcely fair to expect the busy general practitioner to form a considered opinion, for it may involve inquiry into non-medical matters—e.g. the kind of remunerative occupation which is, in fact, available. It is true that the responsibility of deciding for how long cash benefits should, in such cases, continue rests with the Approved Society, but the doctor has

still to decide when the incapacity certificates shall cease. Now these are typically cases which, it is suggested, should be referred to the R M O. It is one of the specific duties of that officer to decide cases of this kind, and there seems no reason why the practitioner should not free himself of unnecessary responsibility by taking advantage of the machinery which has been provided. At present, nearly all R M O references are originated by Approved Societies, and this tends to create an impression unfavourable to the doctor. It is sometimes feared that such references will involve loss of time to the busy doctor, in view of the requirement that he must attend at the examination if required to do so. In practice, however, the R M O studies the convenience of the doctor and does not unnecessarily require his attendance. In any case, a reference by the doctor himself will ordinarily involve less annoyance and loss of time than will an ultimate reference by the Approved Society.

IRREGULARITIES IN CERTIFICATION "OBLIGING THE PATIENT"

Most of the irregularities in certification can be traced to a few causes, which will here be briefly discussed. It is proposed to exclude from consideration cases of wilful misfeasance. A glance at the figures of certification complaints investigated by insurance committees suggests that such cases are relatively rare. The total number investigated by all committees in the British Isles from 1920 to 1923 was only 434, representing approximately one complaint for every 30,000 insured persons over a period of nearly four years, even in these cases the offence was sometimes trivial, and not infrequently the action of the doctor was upheld. But the figures following upon the coal strike have been very different as far as application to the referees is concerned, and no doubt a grave difficulty has been introduced into medical certification by the wide unemployment. Sympathy with economic straits must not lead to the granting of sick certificates, but on the other hand, those straits do lead to sickness. In this dilemma it is the

doctor's duty to help in the administration of the Acts, whatever his inclination may be, and however sure he may feel that his strictness will lead to the loss of patients under a too easy system of transfer

One fruitful source of trouble has been the attempt by the doctor to assist a patient in a technical difficulty. The certification rules definitely provide that

1 A first or intermediate certificate need be issued only at the request of the patient

2 A final certificate, whether asked for or not, must be issued as soon as the patient is found to be fit to return to work, but it may not be issued if the patient has already returned to work

3 All certificates must be given within 24 hours of the examination to which they relate

Cases frequently arise where a patient neglects to ask for a first or intermediate certificate at the time of examination, and subsequently (more than 24 hours later) applies for a certificate to produce to his society. Or a patient who has been receiving intermediate certificates may return to work without consulting his doctor and may subsequently ask for a final certificate. Hitherto the doctor has not, in such cases, been allowed to use one of the official forms, and he has had to choose between either writing out a special manuscript certificate or an explanatory letter (probably resulting in further inquiries from the society) or refusing a certificate with possible loss of benefit to the patient. In these circumstances many doctors have felt themselves justified in using the regular form of certificate in technical breach of the regulations.

The voluntary certificate introduced in January 1924 meets these cases and, if properly used, should entirely remove this particular form of irregularity. The certificate states that the patient was examined on particular dates and was, in the doctor's opinion, incapable of work during a specified period. It is expressly intended for use where, through any action on the part of the insured person, the issue of one of the regular certificates is forbidden. It is

issued at the doctor's discretion and the doctor is allowed to charge for its issue

In future, therefore, a safe rule will be that in cases of doubt *due to the action of the patient*, the voluntary certificate should be issued. Thus, the patient's interests are served by providing the society with the necessary evidence, the action taken on that evidence is, of course, a matter solely for the society. The voluntary certificate should not be used when the irregularity is due to the doctor's own action. For example, if the patient duly asks for a certificate at the time of examination, but the doctor, not having one at hand, neglects to send one within 24 hours, the regular form of certificate should be used, the actual dates of examination and of signing being entered¹

¹ With regard to the statement that where a doctor neglects to grant an intermediate certificate within 24 hours of seeing the patient he should not use the new voluntary certificate, but should use the "regular form of certificate," it has been suggested that the doctor should give one of his own private certificates or write on a plain piece of paper, Rule 8 being the authority for the view. Rule 8, considered by itself, might suggest this interpretation. Rule 2, however, limits the use of the prescribed forms of certificate by providing that these forms "shall not be used on any occasion on which the practitioner is not required by these Rules to give a certificate." This clearly prohibits their use where the insured person is himself responsible for a delay in the issue, for in such a case the doctor is not "required" to give a certificate but may use the voluntary or a private certificate as an act of grace. Article 2 does not, however, seem to exclude the issue of a regular certificate where the patient has made due request, and the doctor has neglected to give the certificate within 24 hours, for then, in spite of his dilatoriness, the doctor is still "required to give a certificate." Rule 8 merely defines the doctor's obligation as to the time when the certificate is to be issued. If, after due request, the doctor neglects to issue the certificate within 24 hours of the examination, he admittedly commits a breach of this rule, but the insured person still remains entitled to receive the regular certificate for which he asked at the proper time. If it were otherwise, what would become of the requirements in Rules 3, 4 and 5 that the doctor *shall*, if desired by the insured person, issue a first or intermediate certificate? The breach by the doctor of Rule 8 cannot be held to render the other rules of no effect.

In the memorandum, Form G P 37, which was sent to insurance doctors when notice was given of the altered terms of service under the Medical Benefit Regulations, 1924, the Minister of Health thus explains the point (para 10 (c)) "It should be specially noted that they [the voluntary certificates] cannot properly be used in cases in which the practitioner

Handy Certificate Books

Complaints of irregular certification have, again, often arisen because the doctor had not the appropriate form to hand at the time of examination, and the writing of the certificate was afterwards delayed, perhaps through a succession of urgent calls. This has sometimes led to formal complaints of wilful retrospective certification. The difficulty is now largely removed by a more convenient printing and binding of the certificates. Excepting the voluntary and death certificates, which are printed separately, there are now only two forms, on one is printed the ordinary first, intermediate and final certificates, while the other contains the special intermediate and convalescent certificates. Moreover, all the certificates, with the sole exception of the voluntary certificate, can be obtained bound in one book in suitable proportions, this book includes even the special notice to be given when intentionally vague certificates are issued. The doctor can, therefore, now conveniently carry a selection of every form of certificate required. Although the ordinary and special certificates are also issued separately in two books, the possession of a composite book by every doctor should prove of considerable convenience as an addition to an emergency kit.

PRESSURE BY SOCIETIES DIFFICULTIES OF DIAGNOSIS

There is ground for legitimate complaint that while the Approved Societies actively criticize irregular certification, they not infrequently, either directly or indirectly, themselves bring pressure to bear on the doctor to vary his normal certification practice. Sometimes the patient will press for a certificate which the doctor considers not to be regular,

was himself at fault in not issuing within the required time a certificate which it was his duty to issue. In cases where the patient was not at fault but the doctor has omitted to give or send a certificate within the time specified in Rule 8, an ordinary official certificate should be issued, showing the date of examination and the date of signing. The "ordinary official certificate" in this passage means any of the prescribed forms of certificate other than the voluntary certificate, and therefore, of course, includes Form Med 40 revised.

urging that it is being demanded by the society, sometimes the society's agent may press for certificates to be given on special days to accord with the society's paying-out time

Cooperation between the doctor and the society is obviously desirable where it can be attained with due regard to the doctor's work and to the patient's interests. The sole discretion as to the withholding of a certificate or as to the date of a patient's examination rests, however, with the doctor, and it is believed that there would be a considerable improvement in the whole system of certification if the doctors more resolutely refused to issue certificates in circumstances of doubt until the doubtful point had been decided by the competent authority. The complaints so querulously voiced about certification irregularities on the part of doctors seem often to overlook the difficult position in which the doctor may be placed through irregularities on the part of the patient. It rests, however, largely with the doctors themselves to encourage a stricter observance of the regulations by the insured persons. The regional medical officers, the insurance committees and the health insurance inspectors are the authorities available for deciding cases of doubt, and the maximum use should be made of their services. The patient who, in the doctor's opinion, improperly presses for a certificate should be referred for advice to the local inspector, while the doctor should seek the guidance of the insurance committee.

While societies have complained that the incapacitating cause is often not sufficiently indicated on the certificates, the profession have resented inquiry by societies into the adequacy of diagnosis. The certification rules provide that the incapacitating cause shall be stated as concisely as knowledge permits. On this point only two observations can here be made. Many societies have now formulated schemes for additional benefits, and those schemes sometimes provide for defraying the cost of certain special forms of treatment, which do not fall within the scope of medical benefit. It is, therefore, clearly to the patient's interest that the incapacitating illness should be

shown with sufficient clearness to enable the society to consider whether the member should be assisted in obtaining special treatment Further, now that the composite certificate books include the special notice to be given to societies when intentionally vague certificates are issued, the plea that the special form was not available can offer no excuse for the practice of covering up the real incapacitating cause by indicating some resulting condition—e g debility—just sufficiently to avoid vagueness

PART III

STATUTORY OBLIGATIONS AND PROFESSIONAL DISCIPLINE

CHAPTER XIII

THE GENERAL MEDICAL COUNCIL

Constitution—Functions—Registration Legal Status of Qualified Practitioners—No Restriction on Medical Theory—Purification of Register Penal Powers of Council—Penal Procedure “Infamous Conduct,” Suspension and Erasure—The Warning Notice—Summary

THERE is much misconception in regard to the General Medical Council, not only amongst the public, but amongst members of the medical profession themselves, who ought, as registered practitioners, to appreciate their statutory obligations as well as the disciplinary procedure regulating the relations between medicine and the public. How the Council is composed, what are its duties, and how these are carried out may be found in the documents prefixed to the Medical Register, in the published Minutes and Standing Orders of the Council, in the public Addresses of the Presidents, and in Harper's *Legal Decisions upon the Medical and Dentists Acts* (Constable & Co.), while the Memorandum of the Registrar, published in the *Lancet* on February 6, 1926, and closely followed here, summarizes the essentials.

CONSTITUTION

The Council was constituted under the Medical Act, 1858, and its composition was somewhat altered by the Act of 1886. It now consists of eighteen members appointed by the universities in the United Kingdom having medical faculties, of nine members appointed by the medical corporations, such as the Royal Colleges of Physicians and Surgeons, of five members appointed by His Majesty in

Council, and of six members directly elected by members of the profession as a whole—a total of thirty-eight. To these are added three dentists who are members of the Dental Board, and are appointed for dental business. The universities may appoint either medical men or laymen, generally it is not the medical faculty of the university that appoints the member, but the academic governing body, whatever that may be. In Cambridge, for example, he is elected by the members of the Senate, in the same way as the representatives in Parliament. The representatives of the medical corporations must be members of these bodies, and consequently must be registered practitioners. The representatives nominated by His Majesty in Council are generally appointed for special reasons, relating to departments of the public medical service. For instance, the chief medical officers of the Public Health Departments in England, Scotland, and Ireland have been or are among them, the medical editor of the *British Pharmacopœia*, 1914, was recently appointed by the Crown with reference to his special knowledge of this department, for many years before the formation of the Dental Board a distinguished dentist was appointed to represent Dentistry, and the Chairman of the Central Midwives' Board for England was appointed soon after that body came into being, when the Rules of the Board became subject to the approval of the Council. The direct representatives are practitioners elected, four from England, one from Scotland, and one from Ireland, by ballot of all the members of the profession having registered addresses in these countries respectively. The nominees of the Privy Council and the direct representatives of the profession are appointed for five years. The representatives of the universities and medical corporations may be appointed for five years or less. Thus the eighteen members appointed by the universities, and the five members appointed by His Majesty in Council, may all be laymen—the last Crown member to be appointed was a layman, and the appointment forms a precedent.

The functions of the Council are largely concerned with medical education, and consequently the universities have found it expedient to appoint members of their body conversant with this subject, and the Privy Council have found it desirable to appoint persons having special knowledge of certain subjects of public importance, which might not otherwise be represented

It is important that the constitution of the Council should not vary too quickly, because the Council meets only twice a year, and its executive committee only three or four times. It naturally takes some time for members to become acquainted with their duties. Moreover, it is important that members should have some knowledge of precedents in regard to education and to judicial decisions. And again, when applications are received from practitioners whose names have been erased from the Register for their restoration thereto, it is desirable that there should be members present who were in attendance when the case was originally heard, and therefore have the circumstances in their personal recollection.

FUNCTIONS

Sins of commission—more often sins of omission—are freely laid to the Council's account, of which, from its very nature and constitution, it cannot be otherwise than guiltless. It is reprimanded for doing what the law says it *shall* do. It is bitterly reproached for leaving undone what the law gives it neither power nor means to do. It is spoken of at one time as the "Parliament of the Profession," yet it has no authority to legislate for anybody, and it cannot make even a by-law for any but its own proceedings. At another time it is scornfully described as a "doctors' trade union", yet it cannot legally levy an annual subscription, or say a word on the matter of rates of pay, or hours of work, or disputes with employers, or theories of practice, it offers no pecuniary benefits or strike-pay, and it *can* be sued in the courts like any other corporation. It exists in fact for the protection of the public, not of the profession.

Registration Legal Status of Qualified Practitioners

The Council is, in fact, neither a parliament for making professional laws nor a union for protecting professional interests. When the Council was created nearly seventy years ago, the declared purpose of the legislature was not to promote the welfare of professional men or professional corporations—it was not to “put down quackery,” or even to advance medical science. The object in view was simply the interest of the public. The preamble of the Act of 1858 consists of two lines only: “Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners. Be it therefore enacted.” This preamble, as will be seen, recognizes two kinds of practitioners: the “qualified” and the “unqualified.” Up to that time (1858) no easily understood line was drawn between the two, and when the public desired to make a choice, they were frequently at a loss. The Act set up machinery for, as it were, hall-marking the qualified practitioner, so that he might easily be recognized when his services were required. But the public were left free then, as they are free now, to seek medical aid from the unqualified practitioner if they like. And the unqualified practitioner was left free then, as he is free now, to practise for gain among those who choose to employ and pay him. He was forbidden, under penalties, to pretend that he was qualified, by taking a title he did not possess; he might not use the courts for the recovery of his charges; he could not give a valid certificate of sickness or death; and now by the Regulations made under the Dangerous Drugs Act, he cannot prescribe certain dangerous drugs, like cocaine or morphine, but except for these and a few other not very inconvenient disabilities, he is untouched by the law.

On the other hand, the qualified men, as a set-off to their legal status and official recognition, have been subjected to a central control, educational and disciplinary. They obtained no monopoly of practice among the public.

in general They were afforded no special protection against the competition, not always scrupulous or insignificant, of the uncontrolled unqualified practitioner

The qualified practitioners might fairly have claimed that it would be good for the public, as well as for themselves, if monopoly of practice, and protection against the competition of the untrained, had been conferred upon them In other countries, and in other parts of the King's Dominions, the restriction of practice to the qualified is with general consent and approval enforced by law There, any unqualified person who habitually and for gain practises or holds himself out as practising any branch of medicine or surgery is liable to severe penalties In this country, indeed, the practice of dentistry and the practice of midwifery have been by law restricted to qualified persons But in these days it requires some resolute ignoring of the signs of the times to believe that legislation restricting the practice of medicine and surgery to qualified persons is either probable or possible with us

No Restriction on Medical Theory

In one significant respect, however, the Council is empowered to protect the aspirant to qualification—not against the competition of the unqualified, but against the possible action of the licensing bodies in restricting his freedom when qualified Section 23, Medical Act, 1858, reads thus “23 *Privy Council may prohibit attempts to impose restriction as to any theory of medicine or surgery by Bodies entitled to grant certificates* —In case it shall appear to the General Council that an attempt has been made by any body, entitled under this Act to grant qualifications, to impose upon any candidate offering himself for examination an obligation to adopt or refrain from adopting the practice of any particular theory of medicine or surgery, as a test or condition of admitting him to examination or of granting a certificate, it shall be lawful for the said Council to represent the same to His Majesty's Most Honourable Privy Council, and the said Privy Council may thereupon

issue an injunction to such body so acting, directing them to desist from such practice, and in the event of their not complying therewith, then to order that such body shall cease to have the power of conferring any right to be registered under this Act so long as they shall continue such practice" A practitioner trained and tested in the knowledge essential for public safety, may adopt any theory of medicine or surgery in which he honestly believes

The Medical Register

The instrument which Parliament set up for the purpose of marking the distinction between qualified and unqualified persons is called the Medical Register. And the making and keeping of this Register is entrusted to the Council. On the Medical Register are placed the names of those who have passed certain tests of professional fitness. These are called registered practitioners, and these alone the law declares to be duly or legally qualified. The Council has to see that the tests of professional fitness actually applied by the examining bodies to aspirants for registration are sufficient. The tests must ensure that all those who pass them possess "the knowledge and skill requisite for the efficient practice of Medicine, Surgery, and Midwifery." The Council has also to see that no registered person, who by crime or misconduct has become unworthy of the legal status which registration confers, shall remain on the Register. In other words, the two great functions which the Council in the public interest discharges are, first, to prevent the unfit from gaining access to the Register, and, secondly, to remove the unworthy from it. Except as to a few subsidiary matters, such as the preparation and issue of the British Pharmacopœia, the control of Diplomas in Public Health, the scrutiny of the Midwives' Rules, and the like, all its powers and all its work in relation to the medical profession have reference to these two functions.

It is a Council of *Education* and a Board of *Registration*, under the supervision of the Privy Council, which may

direct it to amend its errors, if any, or supersede it if it persists in them

PURIFICATION OF REGISTER · PENAL POWERS OF COUNCIL

The performance by the Council of its duties in regard to education is not here in question, but the foregoing shows how large a part of its duties are connected with education, and why the members elected by the Universities and appointed by the Crown have hitherto been members of the medical profession rather than laymen

The Council, in fulfilment of its function as a Board of Registration, partly by the force of necessity and partly in virtue of the interpretation of the law by judges, has become a professional court of justice, a domestic forum for the trial and determination of grave charges brought against registered practitioners in their professional capacity. By successive judicial decisions of the High Court and Court of Appeal, it has been laid down that in its procedure the Council, sitting as a tribunal, must as nearly as possible follow the forms and rules customary in other courts. But it has no authority to compel the attendance of witnesses, to administer oaths, or to call for the production of documents. It has only one judgment to give when a charge of misconduct is proved to its satisfaction, namely, "guilty of infamous conduct in a professional respect", and only one sentence when judgment is given, namely, "erasure from the Register". From this sentence and judgment, given after proper inquiry and without malice, the High Court of Justice has pronounced that there is no appeal. In the earlier years of the Council's life, its decisions were frequently called in question before the higher courts of law. The results were on the whole fortunate, for while its actual findings as a professional tribunal were never reversed, the judgments delivered on these appeals not only defined, but in effect prescribed, the jurisdiction of the Council. They laid down its procedure, they interpreted broadly the meagre

language of the Statute, and they settled beyond dispute the finality of its judicial decisions in all causes within its competence

All the Act says is "If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register" In 1863 the then Lord Chief Justice and his colleagues of the Queen's Bench laid it down that this clause "makes the Medical Council sole judges of whether a medical practitioner has been guilty of infamous conduct in a professional respect, and this Court has no more power to review their decision than they would have of determining whether the facts had justified a conviction for felony or misdemeanour under the first branch of the section The Council is the tribunal to whom the Legislature has left the decision, as being the best judges in the matter, and this Court cannot interfere"

In another appeal Lord Justice Bowen declared that, provided "due inquiry" had been made by the Council, "the jurisdiction of the domestic tribunal, which has been clothed by the Legislature with the duty of discipline in respect of a great profession, must be left untouched by courts of law" As to the language of the Statute, Lord Justice Fry added "'Inquiry,' and 'judgment,' and 'guilt' are all words which express and which are relevant to a proper form of judicial proceedings, and, therefore, although this body proceeds by different rules of evidence from those on which courts of law proceed, I cannot for a moment doubt that the Council were proceeding judicially, nor can I help adding that the manner in which the Council has proceeded on this inquiry, as on all other inquiries, shows that the Council are fully aware that they are performing judicial duties, and endeavour evidently to perform them in a very admirable manner"

These and like judgments settled the jurisdiction and the procedure of the Council sitting as a tribunal. The meaning and scope of the statutory verdict of the Council—"guilty of infamous conduct in a professional respect"—were given by the definition of the Court of Appeal in 1892 "If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the Council to say that he has been guilty of 'infamous conduct in a professional respect'." The words "infamous conduct," in fact, constitute a technical legal expression, defined by the Lords Justices to mean conduct "disgraceful or dishonourable" in a qualified professional man acting as such.

PENAL PROCEDURE "INFAMOUS CONDUCT"

The Council, in carrying out its duties under Section 29 of the Medical Act, takes notice of inquiries under two heads, viz those relating to convictions in a court of law, and those relating to "infamous conduct." To deal with all such cases, the Council has set up a Special Committee of five, which, assisted by the Judicial Assessor and the solicitor, acts the part of a grand jury, and considers whether there is *prima facie* evidence calling for a formal inquiry by the Council, or whether the circumstances suggest that a letter of warning may suitably be sent, or whether in the absence of relevant evidence no further action is necessary.

With regard to convictions, the Council, by the direction of the Home Office in England, and the corresponding authorities in Scotland and Ireland, receives from the police all over the kingdom reports of conviction of medical practitioners for any offence whatsoever. Some of these are trivial, such for instance as having the number-plate of a motor-car unlighted, or exceeding the speed limit. In these cases the Council, as a rule, takes no action beyond recording the fact of the conviction. Other cases may be

those of convictions for drunkenness, and unless this conviction is for an offence committed when in attendance on a patient, or (say) when in charge of a motor-car, it is usual to issue a warning to the convicted practitioner. But should further convictions of the same sort be reported, the Committee may think that they indicate a habit of intemperance which might be dangerous to the practitioner as a professional man and to the patients under his charge, in this case it might be decided that for the protection of the public the practitioner should be summoned to appear before the Council. There are other convictions of a still more serious nature, such as those of felony, in which, obviously, the Council ought forthwith to consider the matter in relation to the practitioner's professional status, and to the good repute of the Register.

If an allegation of "infamous conduct" is received, the Standing Orders¹ prescribe that the complaint must be formulated in writing, stating the grounds of complaint and accompanied by one or more statutory declarations as to the facts alleged. The practitioner, if the complaint is relevant to his profession, is then asked to give such explanation of the matter in writing as he may think fit, and the complaint and the answer are brought before the Special Committee. If, in their opinion, a *prima facie* case has been made out to justify an inquiry by the Council, the practitioner is in due course summoned to appear. In cases in which a practitioner has been under the censure of a judicial or other competent authority in relation to his professional character, as the result, for instance, of an inquiry into professional conduct held under the National Insurance Acts, or of a trial in the civil courts, statutory declarations by the authority in question are not required, but the depositions, judgments, and all relevant documents, are officially supplied, and in other respects the same procedure is followed by the Council.

When the inquiry takes place, the complainant or complainants may be represented by counsel or solicitor, or

¹ These are published by Messrs Constable & Co

in the event of there being no personal complainant or lawyer representing him, as for instance in the case of a criminal conviction, the facts may for convenience be laid before the Council by its own solicitor, who formally proves the conviction and informs the Council of the circumstances as reported - The practitioner is entitled to be, and as a rule is, present, and he also may be represented by counsel or solicitor. The hearing is in public, witnesses are called and examined and cross-examined, as in the ordinary courts of law. Questions may also be put to witnesses by members through the Chair. The Judicial Assessor is always present to assist the Council in regard to any points of law or procedure which may arise, and if there is a conflict of evidence, he, as a rule, sums up and indicates the legal weight to be attached to each part, in the same way as a judge sums up for a jury. When a criminal conviction has been proved, it has to be accepted as a fact, and the Council does not re-try the charge which led to the conviction, any more than, according to Lord Chief Justice Cockburn, the High Court would do, but it is willing to hear anything that the accused practitioner may have to say, or may desire to be said on his behalf, in regard to the actual gravity of the offence of which he was found guilty, and in particular to its relevance to his profession, as affecting his position on the Medical Register. At the conclusion of the hearing the public and the parties withdraw, including the Council's solicitor, if he has been called on to lay the actual facts before it, and the Council then deliberates upon the case in camera. It decides first, whether sufficient evidence has been produced to enable it to come to a decision on the facts alleged, secondly, whether the conviction, or facts alleged in the charge, have been proved to its satisfaction, thirdly, whether it will proceed to judgment at once, or postpone it to a future date, and fourthly, if it does not postpone judgment, whether, on the facts proved, the name of the practitioner is to be erased on the ground that he has been convicted of a grave offence, or is guilty of "infamous conduct in a

professional respect " A full shorthand note of the whole proceedings is taken, and copies are accessible if they are required, either by the Council itself or by any competent authority

Suspension and Erasure

The practice of suspending judgment to a later date is one which has been gradually evolved by the Council The Act gives one penalty only, viz that of erasure, but there are cases in which, when a practitioner has, for instance, been previously convicted of drunkenness and promises amendment, the Council suspends judgment in order that he may have time to show that his word is good, and in this event the practitioner is summoned to appear in six or twelve months' time and to produce evidence as to his good conduct in the interval At the adjourned hearing, if the evidence of conduct is satisfactory, the Council, although it may have found the conviction or the facts, as the case may be, to have been proved, does not deem it necessary to proceed to judgment or to direct the erasure of the name from the Register, and the accused practitioner is "discharged with a caution" The Minutes of the Council record many examples of such "cautions"

A practitioner whose name has been erased may, under the conditions set forth in the Standing Orders, apply to have it restored, and, if in the opinion of the Council it will not be prejudicial to the public interest to grant his request, his name is replaced on the Register The Council has no jurisdiction over the licensing bodies in regard to the withdrawal, under their by-laws, of their qualification from one of their own members or licentiates Certain bodies, for instance many of the universities, have no statutory power to withdraw their degrees once they have been conferred Others, such as the Royal Colleges of Physicians and Surgeons, have power, independently of any action by the Council under their own by-laws to suspend or expel their members for offences involving a breach of their particular regulations or of the practitioner's

declaration on admission When a practitioner applies for restoration it is essential, in order to conform to the law, that he should actually be in possession of at least one qualification, for restoration is in effect re-registration If he is not, the Council has no power to restore his name only, for he is, in fact, unqualified He must therefore first apply to the bodies whose qualifications he formerly held, asking to have at least one qualification restored to him In this matter the licensing bodies have necessarily complete autonomy They are not bound either to await or to follow a decision by the Council

THE WARNING NOTICE

Covering and Advertisement

It is the custom of the Council from time to time to issue warning notices to practitioners in regard to points of professional conduct, and it has been the practice not to issue such a warning until a number of cases of a particular form of misconduct have been brought before the Council, so that it is clear that a state of things is becoming prevalent which is contrary to the public interest For instance, in certain parts of the country it was formerly customary for a qualified man in large general practice to employ a number of unqualified persons as his assistants These, as they acquired a certain amount of rule-of-thumb experience, were gradually entrusted more and more with the sole care of patients The practitioner sometimes did not see the patient until it was time to sign a death certificate in order to avert an inquest Individual cases of gross abuse were one by one brought before the Council and condemned Others, in which serious forms of evasion of the law were attempted, followed upon these, and as they arose these ingenuities were severally met and dealt with At length it was made clear to those who clung to the bad tradition that its exercise was too dangerous to be profitable, and that the unqualified assistant must go Having accumulated a sufficient body of experience regard-

ing the mischief which had to be remedied, the Council summed up all in a Warning Notice respecting the professional offence of "covering." All qualified practitioners were notified that the abuse of their qualifications, whereby an unqualified person was enabled to mislead the public and to treat patients as if he were qualified, under "cover" of his qualified employer or employee, who might sign for him his medical certificates, and otherwise enable him to evade the law, was in its nature fraudulent and dangerous to the public health, and that such an offence rendered them liable to be judged guilty of "infamous conduct." The result was remarkable. Unqualified assistants were dismissed wholesale, often no doubt at the cost of some hardship to individuals, but in the end for the good of the public and the profession alike. The evil, from being almost endemic in particular districts, became sporadic, and has now almost passed away. Other forms of "covering," such as those by which uncertified women were enabled to practise as midwives, and other unqualified practitioners were enabled to procure medical certificates from the qualified, were one by one dealt with as they arose, private interests not prevailing against those of the public.

More recently the practice of advertising, whether directly or indirectly, for the purpose of obtaining patients or promoting a practitioner's professional advantage, was brought before the Council in connexion with some particularly flagrant cases, and each case had to be judged on its merits—or demerits. The character of the advertising varied. In some cases articles were inserted in the press, either by the practitioner himself or through the medium of complaisant journalists, affirming directly or by implication the superior methods of treatment of a practitioner, who desired for gain to attract patients to himself at the cost of his self-respect, and the respect of others. If this procedure were unchecked, the practitioner who had fewest scruples in praising himself and his wares would reach the widest public, and extend his practice without any guarantee that his merits were in fact superior. It was discreditable

to his profession, and contrary to the public interest, that a qualified man should thus adopt the methods of the unqualified self-advertising and self-praising practitioner of medicine or surgery. Accordingly the Council warned the profession against conduct of that kind, and, where a formal and duly attested complaint of such conduct is received, it holds an inquiry into the alleged facts. When the inquiry elicits evidence of deliberate bad faith, or of wilful exploitation of the public for gain, the offence of "unprofessional advertising" is held to be aggravated. But it may be added, that the publication in the press of articles on medical subjects by medical practitioners has not been condemned by the Council, unless it has been proved that the articles come under the terms of the Warning Notice, or are otherwise of an objectionable character.

SUMMARY

To sum up what has been written in regard to the disciplinary procedure of the Council, it is clear, first, that the Council does not itself initiate proceedings, does not itself employ detective methods, and does not itself act as prosecutor, against registered practitioners. It is a Statutory Court of Justice, and takes action only in cases of criminal conviction, or of judicial censure, officially brought to its notice, or in cases of formal complaints, supported by *prima facie* evidence, brought before it by responsible persons or bodies. Secondly, its judicial procedure is based as nearly as may be on that obtaining in the Law Courts. When a charge is made the practitioner has every possible opportunity of defending himself, and should his name be erased from the Register, it may after a lapse of time be restored thereto, if that can be done with safety to the public. And thirdly, it is now unusual for complaints involving a charge of "infamous conduct" to be lodged in regard to any matter on which the Council has not already issued a general warning to the profession and to the public.

CHAPTER XIV

THE WARNING NOTICES

Warning Notices to Practitioners and Registered Dentists— The Need of Vigilance

WARNING Notices are published by the General Medical Council to bring to the notice of the medical profession, and of the public, the attitude of the Council towards the forms of professional misconduct which have from time to time come regularly before them and have been adjudicated upon by them in the exercise of their disciplinary functions. The following Notice was issued in June 1923, with the definite statement that the offences categorized might be met by erasure from the Register. It is set out below and in subsequent chapters is considered under its seven separate sections. A similar Notice, issued to dental practitioners, is included.

WARNING NOTICE

MEDICAL PRACTITIONERS

THE GENERAL MEDICAL COUNCIL desire to bring to the notice of registered medical practitioners the following statement, which summarizes the RESOLUTIONS AND DECISIONS OF THE COUNCIL UPON FORMS OF PROFESSIONAL MISCONDUCT that have from time to time been brought before the Council in the exercise of their disciplinary jurisdiction over the members of the medical profession.

The jurisdiction is conferred upon the Council by the 29th section of the Medical Act, 1858, which is as follows —

“If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register.”

It must be clearly understood that the instances of professional misconduct which are given below do not constitute, and are not

intended to constitute, a complete list of the offences which may be punished by erasure from the Medical Register and that by issuing this notice the Council are in no way precluded from considering and dealing with any form of professional misconduct (as, for example, immorality involving abuse of professional relationship) which may be brought before them, although it may not appear to come within the scope or precise wording of any of the categories herein set forth. Circumstances may and do arise from time to time in relation to which there may occur questions of professional conduct which do not come within any of these categories. In such instances, as in all others, the Council have to consider and decide upon the facts brought before them.

1 *Certificates, Notifications, Reports, etc*

Registered medical practitioners are in certain cases bound by law to give, or may be from time to time called upon or requested to give, certificates, notifications, reports, and other documents of a kindred character, signed by them in their professional capacity, for subsequent use either in Courts of Justice or for administrative purposes.

Such documents include, among others, Certificates, Notifications, Reports, etc.

- (a) Under the Acts relating to BIRTHS, DEATHS, OR DISPOSAL OF THE DEAD ,
- (b) Under the Acts relating to LUNACY and MENTAL DEFICIENCY and the Rules made thereunder ,
- (c) Under the VACCINATION Acts and the Orders made thereunder ,
- (d) Under the FACTORY Acts and the Regulations made thereunder ,
- (e) Under the EDUCATION Acts ,
- (f) Under the PUBLIC HEALTH Acts and the Orders made thereunder ,
- (g) Under the WORKMEN'S COMPENSATION Acts ,
- (h) Under the Acts and the Orders relating to THE NOTIFICATION OF INFECTIOUS DISEASES ,
- (i) Under the NATIONAL INSURANCE Acts and the Regulations made thereunder ,
- (j) Under the OLD AGE PENSIONS Acts and the Regulations made thereunder ,
- (k) Under the MERCHANT SHIPPING Acts ,
- (l) In connexion with SICK BENEFIT, INSURANCE AND FRIENDLY SOCIETIES ,
- (m) For procuring the issue of Foreign Office PASSPORTS ,
- (n) For EXCUSING ATTENDANCE in courts of justice, in the public services, in public offices, or in ordinary employments ,
- (o) In connexion with NAVAL AND MILITARY matters

132 THE CONDUCT OF MEDICAL PRACTICE

Any registered practitioner who shall be shown to have signed or given under his name and authority any such certificate, notification, report, or document of a kindred character, which is untrue, misleading, or improper, *whether relating to the several matters above specified or otherwise*, is liable to have his name erased from the Medical Register

2 *Unqualified Assistants and Covering*

The employment by any registered Medical practitioner in connexion with his professional practice of an assistant who is not duly qualified or registered, and the permitting of such unqualified person to attend, treat, or perform operations upon patients in respect of matters requiring professional discretion or skill, is in the opinion of the Council in its nature fraudulent and dangerous to the public health, and any registered medical practitioner who shall be shown to have so employed an unqualified assistant is liable to have his name erased from the Medical Register

Any registered medical practitioner who by his presence, countenance, advice, assistance, or co-operation, knowingly enables an unqualified or unregistered person, whether described as an assistant or otherwise, to attend, treat, or perform any operation upon a patient in respect of any matter requiring professional discretion or skill, to issue or procure the issue of any certificate, notification, report or other document of a kindred character (as more particularly specified in Division 1 hereof), or otherwise to engage in professional practice as if the said person were duly qualified and registered, is liable on proof of the facts to have his name erased from the Medical Register

The foregoing do not apply so as to restrict the proper training and instruction of *bona fide* students, or the legitimate employment of dressers, midwives, dispensers, surgery attendants, and skilled mechanics, under the immediate personal supervision of a registered medical practitioner

3 *Sale of Poisons*

The employment, for his own profit and under cover of his own qualifications, by any registered medical practitioner who keeps a medical hall, open shop, or other place in which scheduled poisons or preparations containing scheduled poisons are sold to the public, of assistants who are left in charge but are not legally qualified to sell scheduled poisons to the public, is in the opinion of the Council a practice professionally discreditable and fraught with danger to the public, and any registered medical practitioner who is proved to have so offended will be liable to have his name erased from the Medical Register

4 *Dangerous Drugs*

The contravention by a registered medical practitioner of the provisions of the *Dangerous Drugs Acts* and the Regulations made thereunder may be the subject of criminal proceedings, and any conviction resulting therefrom may be dealt with as such by the Council under the powers given them by Section 29 of the *Medical Act, 1858*. But any contravention of the *Acts* or the Regulations, involving an abuse of the privileges conferred thereunder upon registered medical practitioners, whether such contravention has been the subject of criminal proceedings or not, will, if proved to the satisfaction of the Council, render a registered medical practitioner liable to have his name erased from the Medical Register.

5 *Association with Unqualified Persons*

Any registered medical practitioner who, either by administering anæsthetics or otherwise, assists an unqualified or unregistered person to attend, treat, or perform an operation upon any other person in respect of matters requiring professional discretion or skill, will be liable on proof of the facts to have his name erased from the Medical Register.

6 *Advertising and Canvassing*

The practices by a registered medical practitioner—

(a) of advertising, whether directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage, or, for any such purpose, of procuring or sanctioning or acquiescing in the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services, or qualifications, or depreciating those of others, or of being associated with or employed by those who procure or sanction such advertising or publication, and

(b) of canvassing or employing any agent or canvasser for the purpose of obtaining patients, or of sanctioning, or of being associated with or employed by those who sanction, such employment,

are in the opinion of the Council contrary to the public interest and discreditable to the profession of medicine, and any registered medical practitioner who resorts to any such practice renders himself liable on proof of the facts to have his name erased from the Medical Register.

7 *Association with Uncertified Women practising as Midwives*

It is provided in the *Midwives Act, 1902*, the *Midwives (Scotland) Act, 1915*, and the *Midwives (Ireland) Act, 1918*, respectively, that

"no woman shall habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she be certified under this Act "

And whereas it has been made to appear to the Council that certain registered medical practitioners have, from time to time, by their countenance or assistance or by issuing certificates, notifications, or other documents of a kindred character, knowingly enabled uncertified women, on pretence that such women were under their direction, to attend women in childbirth, contrary to law ,

And whereas such conduct is in the opinion of the Council discreditable to the profession of medicine, and calculated to defeat the purpose of the Statutes made in the public interest for the protection of mothers and infants ,

Notice is hereby given that any registered practitioner who is proved to have so offended will be liable to have his name erased from the Medical Register

DENTAL PRACTITIONERS

The Dental Board of the United Kingdom, after consultation with the General Medical Council, have drawn up a similar warning regarding certain forms of professional misconduct Jurisdiction is conferred upon the Board by the Dentists Acts 1878 and 1921, under which dental practitioners convicted of felony or misdemeanour, or guilty of any infamous or disgraceful conduct in a professional respect, may be removed from the Register The evidence in the cases is forwarded to the General Medical Council, and if erasure from the Dental Register follows, the names will be removed from the lists of licentiates in dental surgery or dentistry of the medical authority of which such persons are licentiates

The Dental Warning Notice only particularizes certain forms of professional misconduct, but the dental practitioner is as liable to punishment as the medical practitioner if he gives improper certificates or if he abuses his professional relationship with the public But no one will be erased on account of the adopting or refraining from adopting the practice of any particular theory of dentistry or dental surgery

The Notice runs as follows

1 *Unregistered Assistants and Covering*

Section 14 (2) of the Dentists Act, 1921, is as follows —

For the purposes of this Act, the practice of dentistry shall be deemed to include the performance of any such operation and the giving of any such treatment, advice, or attendance as is usually performed or given by dentists, and any person who performs any operation or gives any treatment, advice, or attendance on or to any person as preparatory to or for the purpose of or in connection with the fitting, insertion, or fixing of artificial teeth shall be deemed to have practised dentistry within the meaning of this Act

The practice of dentistry, except by persons registered in the Dentists Register or in the Medical Register, is prohibited by the Dentists Act, 1921, and any person who contravenes this provision is liable to be summarily convicted and fined

Accordingly, the employment by any registered dentist in his professional practice of an assistant who is not registered either in the Dentists Register or in the Medical Register, if he is permitted to practise dentistry and in particular to do any of the things specified in the section quoted above, is contrary to law, and any registered dentist who has so acted renders himself liable, on proof of the facts, to have his name erased from the Register

Similarly, any registered dentist who by his presence, countenance, advice, assistance, or co-operation has knowingly enabled an unregistered person, whether described as an assistant or otherwise, to practise dentistry or to do any of the things specified in the section quoted above, renders himself liable, on proof of the facts, to have his name erased from the Register

2 *Advertising and Canvassing*

The practices—

(a) of advertising with a view to procuring patients, or of sanctioning, or of being associated with or employed by those who sanction, such advertising, and

(b) of canvassing or employing any agent or canvasser for the purpose of procuring patients, or of sanctioning, or of being associated with or employed by those who sanction, such employment,

are in the opinion of the Board and of the General Medical Council contrary to the public interest and discreditable to the profession of dentistry, and any registered dentist who resorts to any such practice renders himself liable, on proof of the facts, to have his name erased from the Dentists Register

3 *Use of Titles and Descriptions*

Section 4 of the Dentists Act, 1921, is as follows —

USE OF TITLES AND DESCRIPTIONS A person registered under the principal Act—

(a) shall, by virtue of being so registered, be entitled to take and use the description of dentist or dental practitioner,

(b) shall not take or use, or affix to or use in connection with his premises, any title or description reasonably calculated to suggest that he possesses any professional status or qualification other than a professional status or qualification which he in fact possesses and which is indicated by particulars entered in the Register in respect of him

Any registered dentist who may have infringed the provisions of this Section renders himself liable, on proof of the facts, to have his name erased from the Register

4 *The Prescribed Examination*

Any person who has obtained registration in the Dentists Register in virtue of having passed the Prescribed Examination under the Dentists Act, 1921, is warned against making use of any words or abbreviations calculated to give the impression that registration has been obtained by passing a qualifying examination, or that any such person has been admitted to the Prescribed Examination as a student of a recognized hospital or school

Any person who may have so acted renders himself liable, on proof of the facts, to have his name erased from the Register

THE NEED OF VIGILANCE

The Warning Notices should certainly be read by every practitioner By this advice it is not suggested that any large percentage of our body require to keep a list of professional offences before them so that they may estimate from the category of punishable deeds what to avoid, or how far they may go with impunity Indeed, if anyone should use the Notices thus he would find them misleading, for not only do they make no mention of many forms of professional misconduct, as for example immorality involving an abuse of professional relationship, but also the Notices are not prophetic They are founded upon the experience of the Council in the conduct of the penal machinery, and therefore take into consideration only those classes of offences which have come

before the Penal Committee with any regularity. There is no doubt that an ingenious bad man could act unprofessionally in many ways to which the Council omits formal allusion, but the plea that no official warning has been uttered will not save a genuine offender from erasure.

All whose names are on the Medical and Dental Registers should read the Warning Notices, because to do so will bring home the fact that the responsibilities of practitioners to the public must be discharged with exactitude. This, which will always be a difficult task for some temperaments, is in medical practice rendered especially so because of the varied nature of professional engagements and the unexpected way in which the stress of practice may *make itself felt*. Where the business day is one of ordinary routine it should be easy to discharge its formal duties, but in the medical life the opposite conditions prevail. First among the acts of omission and commission against which the General Medical Council has issued specific caution come the irregularities which may occur in connexion with medical certification. These irregularities are of frequent occurrence, and every medical practitioner should be on his guard against them and perpetually aware of the risks of a lapse.

CHAPTER XV

CERTIFICATES AND NOTIFICATIONS

Birth Certificates—Still-births—Death Certificates—Inspection of the Body—Disposal of the Dead—Cremation—Embalming

THE Warning Notice urges on the practitioner the necessity of being careful in the matter of the issue of certificates, notifications, reports, or any document of a kindred matter whose value either in legal proceedings or for use in other ways depends upon the signature of a qualified medical man. Fifteen classes of document it may be the duty of a medical man to sign in a professional capacity, and there is no doubt that the necessity of extreme accuracy and punctiliousness in their issue is insufficiently appreciated by the medical profession. It is not difficult to see how a perfunctory attitude towards the giving of certificates arose. Medical men were in the past much imposed upon in the matter, so that some of their occasional laxity is no doubt due to the fact that they were asked frequently to discharge this duty—very often asked urgently and at short notice—for which there was no adequate remuneration, and sometimes no remuneration at all. Before the days of the National Insurance Act every sick club had its own rules for the production of these vouchers, while the liabilities of employers and the compensation of workmen, having no statutory recognition, were dealt with in all sorts of irregular ways based on medical testimony. Now the law demands particular certification after due precautions.

The alphabetized sequence in the Warning Notice is repeated in the following chapters dealing with the various certificates.

(a) UNDER THE ACTS RELATING TO BIRTHS, DEATHS,
AND DISPOSAL OF THE DEAD

Under the Acts relating to births, deaths, or disposal of the dead, there is, as might be expected, very little carelessness on the part of doctors—false death certificates are freely handed about in sensational novels, but there, and only in their pages, are, in the oft-quoted words, “venal doctors as common as blackberries” In real life no trouble arises here, although, and of course, the practitioner should follow very strictly the instructions for issuing these documents The practitioner should only certify what he is prepared to affirm on oath—that is the crucial test

Birth Certificates

A medical practitioner is not required legally to register a birth, but in respect of notification he may have a responsibility The onus of notification is laid by law upon the father, but in the case of his default the doctor is likely to be called upon to make the notification The duty is only incumbent upon the father if he is actually residing in the house where the birth takes place and at the time of its occurrence, if he is not there the responsibility may devolve upon the doctor in the character (to quote the Act) of “a person in attendance upon the mother at the time of or within six hours after the birth” If the father is not present, and if no doctor is there or arrives within six hours of the birth, the registration can be effected by the occupier of the house, or anyone present at the birth or having care of the infant The notification has to be given on a form supplied by the public health authorities The practitioner, therefore, must remember the liability that is upon him and discharge it if the father is absent He is well advised to remind the father of his duty, if the father was on the scene at the time, and warn him that notice of the event must be given in writing to the medical officer of the district where the child was born within thirty-six hours of the birth

Still-births

Under the Births and Deaths Registration Act, 1926 (taking effect on July 1, 1927) provision is made for the registration of still-births. A still-born child is defined under the Act as one which "has issued forth from its mother after the 28th week of pregnancy, and which did not at any time, after being completely expelled from its mother, breathe or show any other signs of life." Information concerning a still-birth must, unless there has been an inquest, be given to the registrar by the person who would have been responsible for doing so if the child had been born alive. Such person, on giving information, has either to produce a written certificate that the child was not born alive, signed by a registered medical practitioner or certified midwife who was in attendance at the birth or who has examined the body of the child, or else to make a declaration in a prescribed form stating that no registered medical practitioner or certified midwife was present at the birth or has examined the body or that his or her certificate cannot be obtained, and that the child was not born alive.

Death Certificates

All deaths must be registered, the procedure differing somewhat in England (including Wales) and Scotland. In England and Wales the information of the death, which has to be given to the local registrar within five days of the event, is worthless without a medical certificate. Where for any reason the medical certificate is withheld there is a coroner's inquest, and the coroner's certificate is sent to the registrar. A registrar's certificate or a coroner's order is an essential preliminary to the final disposal of the body.

There is a growing feeling that medical men, before giving death certificates, should actually themselves see the corpse, but the necessity is not a legal one. In cases where legal proceedings might subsequently play a part the doctor is almost sure to have seen the body either at the instance of the relatives or on his own initiative, when he is proposing

to refuse the certificate, or at any rate while he is doubtful if he will give one. It is easy to understand that this duty, for which no statutory charge can be made, might sometimes be irksome to the doctor and often be completely unnecessary. It is required that he should view the body either that he may ascertain that there is a body to view or that the body is that of the man whose death is being certified. Neither doubt can often arise, and probably for this reason the doctor is not enjoined by law to see the body before certifying the death.

The suggestion that the subject for whom the certificate is required may not be dead belongs largely again to the realm of fiction. Here a body not that of the presumably dead person is often procured to meet the regulations for the disposal of the dead. In the stories the supposedly dead person disappears, either in order to enjoy ill-gotten gain or to avoid legal process—the robbery of an Insurance society is the usual motive. This manœuvre has been attributed in real life to certain notorious people, notably Sadleir, the Irish financier, who was widely believed to have imitated suicide by the purchase of a body from a workhouse. The episode formed the foundation of one of Miss Braddon's early novels, but, as a matter of fact, the Sadleir myth was exploded by the founder and editor of the *Lancet*, who was conducting the actual inquest as coroner for Middlesex, and who knew Sadleir personally in the House of Commons. Wakley identified the body, and saved the criminal authorities the trouble of inquiry into the rumours, which persisted, however, for many years.

There was a case which was actually made the subject of legal inquiry where a man not only provided no corpse, but himself called on the doctor, in the character of a mourning brother, and obtained his own death certificate. His trick was discovered before any fraudulent use could be made of the certificate, and for success in such a deception so much elaborate planning is required that the possibility of its occurrence is hardly argument for insisting that the

medical man should always inspect the body before giving a certificate, but the event gives support to the view that inspection is always a prudent course, and one that must be taken in circumstances of the slightest doubt or suspicion

Under the Act of 1874 the Registrar-General was required to supply registrars with printed forms of certificate of cause of death to be signed by registered medical practitioners. The Act of 1926 provides that these forms shall be as prescribed by the Registrar-General with the concurrence of the Minister of Health, and makes it the duty of the signing doctor to deliver the certificate forthwith to the registrar, and to give written notice (on a prescribed form) of the signing of the certificate to "some person required by the Births and Deaths Registration Acts, 1836 to 1901, to give information concerning the death"

Disposal of the Dead

The reference in the Warning Notice to certificates necessary in respect of disposal of the dead has particular application to the question of cremation, where a special procedure has to be followed. Neither burial nor cremation can take place without a death certificate, either given by a doctor, or by a coroner as the result of an inquest. In burial the production of a death certificate suffices to enable the registrar to issue to the undertaker a burial certificate, but in the case of cremation other formalities have to be observed. A special certificate, the form of which is provided by the cremation company, has to be given by the doctor who attended the deceased during his last illness, and who can certify definitely as to the cause of death. But this certificate must be accompanied by a further medical certificate from a second medical practitioner possessing certain qualifications. The confirmatory certificate can only be signed by a doctor of not less than five years' standing who must either be appointed for the purpose by some cremation authority, or hold an appointment as a physician or surgeon in a public general hospital of not less

than fifty beds, or be a medical officer, a police surgeon, an "appointed doctor" under the Factory and Workshops Act, or a medical referee under the Workmen's Compensation Act. The procedure is as follows. The medical practitioner in attendance writes his certificate on the form supplied to him by the cremation company and sends it to a second medical practitioner for a confirmatory certificate. Both the original certificate and the confirmatory certificate are then sent to a special referee appointed by the cremation authority, and not until the referee is satisfied can the cremation take place. Where the circumstances of death lead to an inquest there is practically certain to be a post-mortem examination. In this case the certificate of the pathologist who makes the post-mortem upon the direction of the coroner will supersede the other forms.

It has often been pointed out that the process of cremation must destroy evidence of foul play which, in the event of suspicion arising after burial, may well be forthcoming upon exhumation. This was the line taken by many critics of existing legislation at the time of the Armstrong case (*Lancet*, April 22, 1922), but the evidence in that case suggests that if Armstrong had attempted to have his wife cremated the coroner's inquiry would have elicited at an earlier date the evidence which hanged him. The evidence in this case should find its way into the textbooks of forensic medicine, if only because of the lessons conveyed in respect of death certificates. Armstrong's victim was buried on a perfectly accurate medical certificate properly given. The victim died of heart failure, neuritis, and gastritis exactly as the medical certificate stated that she did, while the doctor who gave the certificate could have no reason to suppose that these conditions, which he personally observed, had a primal origin in deliberate poisoning.

The Minister of Health is authorized by the 1926 Act to make regulations, with the concurrence of the Home Office, imposing conditions and restrictions as to disposal otherwise than by burial or cremation, as to the length of time that a body may be retained after death in an inhabited

house or other premises, and as to embalming or preservation. These regulations, which are expressly to be directed towards ensuring both public health and public safety, will deserve the attention of the medical profession. None have yet been made, although while these pages are at press they are imminent, the operation of the 1926 Act, as already stated, was deferred till July 1, 1927.

CHAPTER XVI

CERTIFICATES AND NOTIFICATIONS (*continued*)

General Principles of Lunacy Certification—Risk to Practitioners and Need of Amendment—"Lancet" Extra Number on "Early Mental Disease"—Some Important Points

(b) UNDER THE ACTS RELATING TO LUNACY AND MENTAL DEFICIENCY

RECENT events have revealed to the public what has long been known to the medical profession—that the position of medical men in respect of lunacy certificates is an extremely difficult one. The report of the Royal Commission on Lunacy and Mental Disorder, which appeared in the summer of 1926 as the outcome of two years of work, followed the lines expected by those who attended its public deliberations, for in distinction to the procedure at some other recent Commissions, the evidence was largely taken in open session. The Commission was appointed to inquire into, among other things, the existing law and administrative machinery in connexion with certification in lunacy and mental deficiency, so that the report dealt with the danger of wrongful certification, while in other directions it certainly revealed the anxious situation of the certifying doctor. For the Commissioners pointed out that, while the public must be safeguarded against the presence in their midst of persons of unbalanced minds and dangerous tendencies, the present state of the lunacy law brought the medical profession in serious risk of legal proceedings. It is proposed, therefore, in the report, that doctors shall not be liable to be proceeded against in the civil or criminal court unless they have acted in bad faith or without reasonable care, and that any such proceedings against them shall be stayed by summary application unless the court is satisfied that there has been a wrongful motive or a neglect of precautions.

It was clearly the intention of Parliament that medical men discharging the responsible duties assigned to them under the Lunacy Acts should be adequately protected. Section 330, Subsection (1) states

“ . . . a person who signs or does any act with a view to sign any report or certificate purporting to be a report or certificate under this Act, or does anything in pursuance of this Act shall not be liable to any civil or criminal proceedings, whether on the ground of want of jurisdiction or on any other ground, if such person has acted in good faith and with reasonable care ”

Nothing could be more explicit, but it would appear from a recent judgment that the onus of proving good faith and reasonable care may be thrown upon the physician. Moreover, though it is stated in Subsection (2) of the same Section 330, that a judge may, if so inclined, stay any proceedings against a physician, it does not say that he *must* do so, if he is satisfied that the physician did exercise reasonable care and acted in good faith. The whole position is therefore unsatisfactory, and medical men who do their duty both to their patients and to the community in the most conscientious manner may be placed in an awkward and even serious position.

Position in Need of Amendment

The present state of affairs is so extraordinary that it is surprising any enlightened community can tolerate it. The public provides and equips at very great expense mental hospitals for the treatment of mental disease but certificates in lunacy are required before a patient can be admitted, and upon medical men is placed the responsibility of signing these certificates. Yet it would seem they are not effectively safeguarded in the discharge of this public duty. Years afterwards the findings of medical men in a matter that is peculiarly their province may be reviewed and even reversed by a jury of laymen none of whom had even seen the patient at the time.

All are agreed that the law requires amendment, but

it may be long before anything is actually done, and in the meantime patients have to be treated and certificates must be signed. The medical profession will not stand aside and permit these patients to suffer and to cause grievous suffering to others merely because it may involve some personal risk to help them under existing legal conditions. The risk is real, though doubtful cases are not so numerous as is assumed, and where there is doubt delay rarely does harm. As a rule, the difficulty is not in the signing of the certificate, but in deciding whether hospital treatment is desirable.

PRINCIPLES OF LUNACY CERTIFICATION

The chief consideration in the great majority of cases is the welfare of the patient, it being impossible to secure proper treatment at home. Until patients can be received voluntarily into mental hospitals, large numbers of poor persons must be certified, since in no other way can they be treated effectively. The establishment of psychiatric clinics in large centres of population would to an even greater extent reduce the need for certification. In a minority of cases legal detention is demanded in the interests of the public, and here special care is needed, and it is often desirable to see a patient several times before coming to a decision.

For private patients two certificates by independent medical practitioners are required. They must see the patient separately, and one of them should, if possible, be the usual medical attendant of the patient. This provision alone greatly reduces the risk of legal trouble later on. A single certificate, however, suffices for a pauper patient, and here it must be remembered that the inability to meet the cost of treatment frequently results in the patient being classified as a pauper, although but for this the family is self-supporting. One certificate also, when accompanied by a medical certificate of emergency, suffices for the admission of a private patient as a temporary measure under an urgency order.

In "Early Mental Disease" (*Lancet* Extra Number II)

will be found a series of articles, contributed by well-known specialists, which set out the points of diagnosis in the various conditions, and will be of great assistance in meeting the difficulties of certification.

The Certificate a Legal Document

The certificate is a legal document, and as such it must be judged by legal and not by medical standards. It gives the evidence which justifies the serious step of depriving a person of his liberty. It consists of two parts, usually printed on the forms provided, and sometimes the full meaning is not appreciated by the doctor. First, it states that the patient is of unsound mind and, secondly, that he is "a proper person to be taken charge of and detained under care and treatment." Then follows the reasons for arriving at this conclusion. It is not sufficient to show that the person is insane, it is also necessary to show that he needs to be taken care of and detained.

Facts Observed at the Time of the Examination

These facts constitute the essential part of certification. In some cases, although there is no doubt about the insanity of the patient and the need for detention, he may during the examination give plausible accounts of his conduct or may deny the statements made by trustworthy people. Again, a patient may vary in his mental state, being reasonable when the doctor is present and quite otherwise when he has gone. A second and third examination will in such cases usually suffice to elicit the actual facts.

The most difficult cases are those with mild degrees of mania or melancholia. The former may ruin themselves with extravagance or exhibit serious misconduct, whilst the latter sometimes commit suicide before steps are taken to safeguard them. Whatever is done or is left undone will probably be criticized adversely after the event by somebody. Moreover, in this type of case it will be found almost impossible to describe the condition in terms that

will be convincing to anyone who cannot observe the patient for himself

It is often possible to bring information received from friends up to date by discussing it with the patient Thus "He admitted that he stopped a complete stranger in the street yesterday and asked him why he made an offensive remark and that the stranger denied having spoken at all " Again, the patient's manner and mode of reply when reminded of incidents are valuable evidence "He smiled and appeared unconcerned when I asked him why he struck his mother last Monday " Sometimes the refusal to answer questions is in itself important "When asked why he refused his food and whether it was true that he thought it poisoned, he made no reply " In many cases it is desirable to tell the patient plainly that the state of his mind is called in question, this not only gives him full opportunity of objecting, but the physician is the better able to form an opinion on the mental state

The examination of a patient should never be hurried, notes should be made at the time or immediately afterwards It is important to be certain that the condition observed cannot possibly be due to the effect of sedatives, alcoholic intoxication, febrile delirium, or any purely temporary condition affecting the integrity of the mind

Facts Communicated by Others

These may be entirely omitted, especially, and in many cases, the certificate is better without them Their insertion is necessary when the true meaning of the facts observed by the physician is not clear otherwise

There are many important facts of which the physician may have no personal knowledge, such as the refusal of food, the existence of faulty habits, acts of violence, and much besides The presence of delusions often cannot be asserted with confidence without information from others The patient may declare he is utterly ruined, and if this is given as evidence of insanity it must be accompanied by a statement by a trustworthy informant to the effect that

the patient's belief is not justified. The doctor himself is not likely to know the true financial position. The greatest care should also be taken with regard to delusions of infidelity, it being often impossible to ascertain the truth with certainty, and the chance must be borne in mind that these and delusions of suspicion may have some basis of fact.

A certificate is often strengthened if it can be shown that the patient's manner or conduct has undergone a marked change. The facts observed may perhaps be excused or explained away had they been found in certain other individuals, but when they are opposed to the whole tenor of the patient's former life they are significant. Relatives can give evidence on this point. Nevertheless, a certificate must not rest on information supplied by others, however trustworthy it may be, although such information may be used to great advantage in its support.

The Wording of the Certificate

It is by no means easy to find appropriate words. The certificate should be terse and to the point, and a long certificate is often a weak one. Nevertheless, economy in words must not leave their meaning in doubt. Many words are almost without value unless amplified or illustrated. Such words, for example, as excited, noisy, depressed, abusive, moody, taciturn, unreasonable, and suspicious may be used to describe conduct which is perfectly normal in certain circumstances. A certificate containing the statement, "He was very noisy and abusive, and called me a damned fool," was returned by the Commissioners with the stereotyped reply, "Will the certifier state some facts more clearly indicating insanity?"

In the endeavour to avoid ambiguity it is undesirable to use technical terms. When they are necessary they must be explained or illustrated. For instance, if the word hallucination or delusion is used, an explicit description of the symptoms should follow. It is not enough to say that the patient suffers from hallucinations of hearing. Particulars should be given, such as, "He told me that he

heard the voice of his deceased sister speaking to him last night " In some cases it is almost impossible to word a certificate so as to avoid all conceivable misunderstanding This difficulty, however, is no excuse for the use of loose or vague expressions which give the impression of haste

It is a good plan to write a certificate first in draft, and before copying to go through it with the thought that it may one day be produced in court, and perhaps criticized unkindly by an advocate who wishes to distort its meaning

OTHER IMPORTANT POINTS

Attendant Circumstances — Obviously the physician cannot put all the facts on the certificate, and in a difficult case there is no objection to his attaching to it a memorandum giving additional particulars It should be remembered, however, that all these details have to be copied in the mental hospital and cause much extra work In most cases it suffices to make precise notes of the attendant circumstances and pigeon-hole them carefully Such notes are invaluable if difficulty subsequently arises In court it seems to be assumed that a doctor can remember all particulars of a patient examined years ago, and if no records are forthcoming it is quite possible that an adequate certificate may be made to appear weak and incomplete The admission by the physician under examination that he has forgotten some important fact may create a bad impression

Dates — There are three distinct situations to consider (1) When a patient is received on an urgency order, the medical practitioner signing the certificate must personally examine the patient not more than two clear days¹ before the reception of the patient in the hospital (2) In the case of a private patient the two medical practitioners must separately examine the patient not more than seven clear days before the date on which the petition is presented to the

¹ The term "two clear days" is construed so as to allow two entire days to elapse between the examination and the reception of the patient For instance, in a case of urgency the patient may be examined on a Tuesday and be received in the mental hospital on a Friday

justice of the peace (3) In other cases the medical examination must be made not more than seven clear days before the date of the justice's order

It is obviously unwise to run any risks of the certificate being out of date, which will result in the patient being discharged, and consequently the examination should take place well within the prescribed period

Minor Details—Lack of reasonable care may easily be imputed if the certificate is incorrect or incomplete in its minor details It is astonishing how many certificates fail to describe informants accurately or fail to give their proper addresses Not a few contain some mistake in dates, or omit to give the full names of the patient Marginal notes on the certification form give full particulars of what is required, and in quite 10 per cent of the cases it would appear that they have not been carefully read Medical men, who are chiefly concerned with the welfare of the patient, are apt to be impatient of legal formalities But they should remember that, when the liberty of the subject is involved, accuracy in every item is imperative and none of the details required is unimportant In any case it is unwise to ignore provisions laid down by Act of Parliament

The University of Durham requires every student in his final examination in medicine actually to examine a mental case and sign a certificate in lunacy Whether the ability to discharge properly this duty of the qualified practitioner is made into an examinational test or no, it is certainly wise that in the medical schools the precaution should be taken to instruct all men, in the final stages of studentship, in the really delicate task of making out a proper lunacy certificate

The risk to the practitioner of legal proceedings will be minimized if he remembers that the certificate is a legal document, if he takes pains in the examination of the patient and in the drafting of the certificate, and if he makes notes at the time of the main circumstances which influenced his judgment, and, of course, preserves the notes

CHAPTER XVII

CERTIFICATES AND NOTIFICATIONS (*continued*)

The Vaccination Acts—The Factory Acts—Duties of Practitioners and Appointed Doctors—Certification of Young Persons—The Education Acts

(c) UNDER THE VACCINATION ACTS

THE medical certificates to be given in connexion with vaccination include the following Certificate of postponement of vaccination owing to child not being in fit and proper state to be successfully vaccinated (see 30 & 31 Vict. c 84, s 18), Certificate of postponement of vaccination owing to condition of house or recent prevalence of infectious disease (see 61 & 62 Vict c 49, s 1 (4)), Certificate of insusceptibility or of child having had smallpox (see 30 & 31 Vict c 84, s 20), and Certificate of successful vaccination (see 30 & 31 Vict c 84, ss 21 and 23, and 34 & 35 Vict c 98, s 7)

Forms were originally prescribed by the schedule to the Vaccination Act of 1867 (30 & 31 Vict c 84), but these were superseded by subsequent orders of the Local Government Board (now the Ministry of Health) See Forms B, C, D and E in the Fifth Schedule of the Vaccination Order, 1898 (S R & O 1898, No 728, printed in Statutory Rules and Orders Revised, 1903 vol xiii) Note that Form F in this Schedule seems no longer operative since section 12 of the 1867 Act, to which it applies, was repealed by 61 & 62 Vict. c 49

The Vaccination Acts of 1867, 1871 and 1898 cited above apply to England, but not to Scotland For the corresponding Scottish provisions see the Vaccination (Scotland) Act, 1863 (26 & 27 Vict c 108), ss 8-10 and 23 and Schedules A, B and C

It is not suggested that the practitioner need be familiar

with the section of the Act thus cited above, but it is highly important for the whole profession, where public attention for this or that reason is particularly watchful of medical procedure, that every practitioner should be able to show that he has complied exactly with his legal obligations

(d) UNDER THE FACTORY ACTS

Under the Factory Acts certain duties fall upon all medical practitioners, and others only upon the certifying factory Surgeons, now to be styled "Appointed Doctors"

A Duties of Medical Practitioners Notification of Industrial Diseases

All medical practitioners are concerned with the notification of industrial diseases

Since the Factory Act of 1895 every medical practitioner attending on or called in to visit a patient whom he believes to be suffering from lead, phosphorus, arsenical or mercurial poisoning, or anthrax, contracted in any factory, has been under an obligation to send to the chief inspector of factories at the Home Office, London, a notice stating the name and full postal address of the patient, and the disease from which, in the opinion of the medical practitioner, the patient is suffering, and—according to the new Factories Bill—the name and address of the factory in which he is employed or in which the disease was contracted. In return the practitioner is entitled in respect of every notice sent to a fee of two shillings and sixpence

While the list of diseases included remains the same in the new Bill, the Secretary of State has power by special order to add any other industrial disease, and has in the past used this power in regard to carbon bi-sulphide, chromic acid, toxic jaundice and epithelomatous ulceration due to pitch. Failure to comply with the Act carries liability to a fine not exceeding forty shillings, but, so long as it is not forgotten, the obligation is not onerous, even the notice may be committed to the post without a stamp. Those practising in a district where risk of contracting one of these

diseases exists, such as Bradford for anthrax, and the potteries for lead poisoning, are fully alive to the responsibility, only in other districts is the obligation liable to be overlooked. Notification of the occurrence of lead poisoning in house painters is required and paid for under the Lead Paint (Protection against Poisoning) Act, 1926, Section 73 of the Factory Act, 1901 (dealing with notification of diseases in factories), being applied to the cases of persons employed in painting buildings as if the premises were factories.

These notifications afford information as to the occurrence of industrial diseases, which is carefully followed up by inquiry into causation and means for prevention. They are classified in tabular form, which is issued annually by the Home Office, and monthly in the *Labour Gazette*.

B Duties of Appointed Doctors

We come now to the certificates to be given by certifying factory surgeons. In the consolidating Factories Bill introduced in 1924, that now awaits passing by Parliament, the offices and duties of certifying surgeons are in future to be carried out by "appointed doctors." Hence it seems better in what follows to use the new nomenclature rather than the title which is about to disappear. The difference in title has reference to the way in which the office is filled and not to the duties to be performed.

(1) Certification of Young Persons

The chief duty is that of issuing certificates of fitness for employment of young persons who have attained the age of fourteen but are under sixteen years of age. The appointed doctor must examine such a young person when taken into any employment in a factory and certify him (or her) to be fit for that employment. In practice a register of all young persons employed is kept at every factory, which is so drawn that part becomes the certificate in question when duly signed by the appointed doctor. He

may, however, within his discretion, refuse to certify or give a certificate in respect of employment (i) in any particular factory, (ii) in any group, class, or description of factories, or (iii) in a particular process, or class, or description of work. He may also give the certificate upon condition that the young person concerned shall not be employed unless and until any physical defects specified in the certificate have been remedied, or may require a re-examination of the young person after an interval specified in the certificate. This power of modifying certificates has been found of great value in bringing pressure to bear in getting such things as enlarged tonsils removed. In future the appointed doctor is to be assisted in his work by having produced for his information so much of the school medical record of a young person as may be necessary to enable him to carry out effectively his examination. Already in certain districts this procedure is followed with great advantage.

The appointed doctor may also be called upon to examine and certify as fit, or otherwise, for employment any young person concerning whom a factory inspector may be of opinion that any particular process or kind of work in a factory is prejudicial to his health or the health of other persons. In practice certification under this heading is somewhat unusual.

The Home Office issues instructions to assist appointed doctors in carrying out medical examinations previous to certification.

(2) *Investigations*

Appointed doctors may be called upon to investigate and report to the factory inspector (a) upon cases of death or injury caused by exposure to fumes or other noxious substances, or due to any other special cause specified as requiring investigation, (b) upon any case of death or injury which may be referred to him for the purpose, and (c) upon any case of disease similarly referred to him. The chief investigations deal with cases of disease, such as lead poisoning, concerning which notification has been

sent by general practitioners to the chief inspector of factories. When the appointed doctor, as the result of such an investigation, is of opinion that the worker is incapacitated from work by reason of a compensatable disease, he may forthwith issue a certificate to this effect as required by the Workmen's Compensation Act. The diseases referred for investigation, although they are usually such as are included in the Schedule to the Compensation Act, need not necessarily be compensatable, nor, on the contrary, must all compensatable diseases occurring in factories be referred for investigation.

(3) *Certificates under Regulations Workmen's Compensation Act*

When carrying out periodical examinations, such as are called for under regulations applying to certain trades, for example the lead industries, the appointed doctor, after examining, at the prescribed period, each person employed, must certify in the register, kept at the factory for the purpose, that each person is in a state of health which justifies his continued employment, or, that he is actually suffering from or liable to succumb to (say) plumbism, and must be suspended from employment on this account. Such suspension from employment practically always establishes a claim to compensation, and the appointed doctor may forthwith issue a certificate as required by the Workmen's Compensation Act.

The first step in establishing a claim to compensation on account of any disease included in the schedule to the Act is to obtain from an appointed doctor a certificate to the effect that the claimant is incapacitated from work on account of one of the scheduled diseases. The duties of an appointed doctor under this Act are wider than those included in the Factory Act under which he is appointed, he may be called upon to certify that a coal-miner is incapacitated by reason of nystagmus, or a house painter by reason of lead poisoning, although the occupations of mining or house-painting are not controlled by the Factory Act. The

duties of the appointed doctor under the Compensation Act, which are clear and distinct from those under the Factory Act, are dealt with in detail in the next chapter.

(e) UNDER THE EDUCATION ACTS

Certificates are frequently required from practitioners as to a child's fitness or unfitness to attend school. Non-attendance at school leads to inquiry by the education officer, usually through a visitor or attendance officer, whose specific duty is to report the precise cause of absence, and the primary responsibility of the parents is then very usually shifted to the doctor. If the child is being kept from school on the doctor's orders, there is no difficulty in giving the certificate, but considerable care is required where the certificate is asked for by parents who have on their own initiative kept children at home.

Instances of considerable laxity have been brought to the notice of the General Medical Council in connexion with school certificates. The Warning Notice here was much required, and no one should disregard it.

Children attending elementary schools are supervised by the school medical officer, who is definitely responsible for their welfare. During their school life they are individually examined at least three times, and, where any departure from the normal is suspected or present, special medical supervision is given. Medical certificates from practitioners are given due weight but the responsibility of the school medical service cannot be delegated, and there should be close co-operation between the school medical officer and the local practitioner for their mutual benefit.

Certificates should definitely state the disability and indicate the period of invaliding, even if only a rough estimate be possible. It is a necessary obligation on the practitioner to see the child before giving the certificate, and it is also important for his own protection. Cases have occurred where the practitioner has been the unwitting tool of unscrupulous parents. The attendance of girls between the ages of 12 and 14 is greatly decreased in

comparison with boys of similar ages—investigation has shown that this disparity is not due in the majority of cases to any adequate physical cause, but to the fact that the girls are kept at home to help with the housework. However much we may sympathize with the parents, especially in the present economic position, we must bear in mind the individual interest and future of the child—moreover, it is a statutory obligation for every child to attend school between 5 and until after attaining 14 years of age. It should be noted that Section 138 of the Education Act, 1921, enacts that if a child attains 14 during a term he shall not be deemed to be 14 until the end of that term. It is left to the discretion of the local education authority to fix the leaving age up to 15 years of age.

The practitioner should, before writing a certificate, acquaint himself with the reason for the child being absent from school, as it is possible that the child may have been officially excluded on some such grounds as “the person or clothing of such child is infected with vermin or is in a foul or filthy condition,” or on account of infectious or contagious disease, either as a sufferer or a contact. Further, children may be officially invalided by the school medical officer if, on either physical or mental grounds, they are incapable of attending school. It must be borne in mind that no child is excluded from school unless there are substantial reasons (including the protection of others), and cases have arisen where certificates of fitness to return have unfortunately been given when the specific conditions of exclusion have not been appreciated. In these circumstances lack of mutual understanding between the private practitioner and the school medical officer may bring about the regrettable result of a bench of local justices having to decide on the relative merits of opinions expressed by two members of the same profession.

The provision now made by most education authorities, especially in urban districts, for dealing extensively with all types of delicate and abnormal children is perhaps not sufficiently realized, as may be gathered from the number

of certificates received stating unfitness to attend school, when what is really meant is the child's unsuitability to attend an ordinary elementary school

Special schools exist for the care of delicate, mal-nourished and anæmic children as well as for those suffering from physical and mental defects of all types, and the larger and more progressive authorities also provide facilities for the special education of those who are completely or partially blind, completely or partially deaf, and for stammerers, they also attempt to secure places in residential special schools for those suffering from frequent or severe epilepsy. Prior to admission to any of these special schools the children must be examined by the authority's consulting medical officer, who also visits the schools from time to time for the purpose of general medical supervision. These medical officers must be specially recognized by the Board of Education for the purpose, and on their statutory certificates the attendance of children can be enforced by the courts. Frequently these children are conducted to and from school by guides or conveyed by ambulance when necessary. Experience has shown that these weakly and abnormal children gain greatly in health and happiness when beneficially occupied under the safe conditions prevailing in these schools designed for their especial needs. It must be borne in mind that although there are adequate facilities for dealing with children, the possibilities of dealing with adolescents are small, and reluctance to adopt early the existing facilities often results in later regrets. When dealing with this type of child any recommendations from practitioners should be made to the school medical officer direct, as to a professional colleague, and not through the medium of the parents, otherwise it may lead to much administrative difficulty and confusion.

A point to be specially remembered is that it is the parents' statutory duty to cause the child to be educated, and it is obligatory on the local education authority to see that the parents carry out their duty. In some instances when the authority demands that the child should attend

school, parents adopt the attitude that any medical certificate obtained should be paid for by the authority, and many unsuccessful claims are made on the authority both by parents and practitioners for certificates given. In no case will payment be made by the local education authority for a medical certificate unless special arrangements have been made for the payment.

It is the duty of the local education authority to supervise the fitness of the teaching staff through their appointed medical officer, who has to certify the teacher's fitness to enter the service, and it is on his recommendation that periods of invaliding are granted. He is greatly assisted by certificates from practitioners, especially when they state the invaliding disability and probable period of absence.

It is a further statutory duty of the school medical officer to issue certificates of fitness for employment of children between 12 and 14 years, including those engaged in entertainments.

Should any question of difficulty arise the school medical officer will naturally welcome communications from his professional brethren, since cordial cooperation will lead to smooth working and maintain the prestige of the profession in the eyes of the public.

(f) UNDER THE PUBLIC HEALTH ACTS

The scope of medical certificates under the Public Health Acts varies widely, as the following examples show.

The Regulations of the Local Government Board (now the Ministry of Health) made in 1907 for prevention of cholera, yellow fever and plague on ships arriving from foreign ports contain a form of certificate (in Article IX) to be given by a medical officer of health, if of opinion that a ship is an infected ship or a suspected ship. Article XII contemplates the certifying of cases of persons suffering from cholera, yellow fever or plague on such ships, or from some disease which may prove to be one of those diseases. Article XX contains a form of certificate to be given by the medical officer of health placing conditions on the landing

of persons so suffering. Under Articles XXIV and XXV he can also certify the necessity for destroying mosquitoes or plague-infected rats. Somewhat similar Regulations were made in 1907 as to coasting ships and outward bound ships

Corresponding provisions exist as to Scotland. The Public Health (Infectious Disease Carriers) Regulations (Scotland) of 1921, which introduced an important new principle, provide that a medical officer of health may certify a person to be a "carrier" No form is prescribed.

CHAPTER XVIII

CERTIFICATES AND NOTIFICATIONS (*continued*)

The Workmen's Compensation Act—Notification of Infectious Diseases—The Insurance Act—The Old Age Pensions Acts—The Merchant Shipping Acts—Certification in Connexion with Sick Benefit, Passports, Attendance in Court, and Naval and Military Matters—Two Important Points

(g) UNDER THE WORKMEN'S COMPENSATION ACT

REFERENCE has already been made (in section (d) above) to the grant by an appointed doctor of a certificate stating that the applicant for compensation is suffering from a scheduled disease. Regulations of 1907 provide that, after personally examining the workman, the certifying surgeon shall either give the workman a certificate of disablement or shall certify that he is not satisfied that the workman is entitled to such certificate, and shall in either case deliver his certificate to the workman. The certificate is to be in the form prescribed in the schedule to the regulations. This procedure is governed by Section 8 of the 1906 Act, which was replaced in 1925 by Section 43 of the consolidating Act. The 1925 Act contains a saving clause for any regulations, etc., made under Acts which it repeals and replaces.

The arrangements for submission of a workman to medical examination—under 15 and 16 Geo V, c 84, s 19 (3), replacing the older provisions in the first schedule of the 1906 Act—contemplate the giving of a certificate by a medical referee in certain cases of dispute. The referee is to "give a certificate as to the condition of the workman and his fitness for employment, specifying, where necessary, the kind of employment for which he is fit." As the certificate is to be conclusive evidence between the parties, the referee will naturally be aware of his responsibility. The procedure is governed by the Workmen's Compensation (Medical Referees

in England and Wales) Regulations of 1923 Regulations 10 and 11 direct that the medical referee shall make a personal examination of the workman before certifying, shall consider any statements which may be made or submitted by either party, and shall give his certificate in the form (Form C) prescribed in the schedule to the regulations

Another occasion of certification arises under Section 16 of the 1925 Act (replacing Schedule I (18) of the 1906 Act), where a workman receiving a weekly payment ceases to reside in the United Kingdom, Channel Islands, or Isle of Man He thereby ceases to be entitled to further weekly payments unless the medical referee certifies that the incapacity is likely to be of a permanent nature This procedure is governed as to England by the Regulations of 1923 already mentioned Regulations 15 and 16 thereof direct personal examination before certification and require the certificate to be in the prescribed form (Form E) in the schedule to the regulations Where the certification takes place abroad the procedure is governed and the form prescribed by the consolidated Workmen's Compensation Rules of 1926 (see Rule 66 and Form 66 in the schedule to the Rules)

The Regulations and rules mentioned above apply to England and Wales only, but corresponding provisions have been made for Scotland

(h) UNDER THE ACTS AND ORDERS RELATING TO THE NOTIFICATION OF INFECTIOUS DISEASES

It is the duty of a medical practitioner who becomes aware that his patient is suffering from an infectious disease scheduled under the Infectious Diseases Notification Act, to send immediately to the district medical officer a certificate giving the patient's name and address and the disease from which he or she is suffering according to the diagnosis which is made Certain diseases are scheduled in the Act for which the certificates of notification are required, while to these there have been added others which are notifiable under regulations made by the Ministry of Health

under Section 130 of the Public Health Act, 1875 Further, any local authority has the power to increase the list and include any other infectious disorder

At the beginning of 1927 the following are the diseases which require notification upon their diagnosis by the practitioner

Anterior Poliomyelitis (Acute)
 Cerebro-spinal Fever
 Cholera
 Continued Fever
 Diphtheria (or Membranous Croup)
 Dysentery
 Enteric Fever
 Erysipelas
 Encephalitis Lethargica (Acute)
 Malaria
 Ophthalmia Neonatorum
 Paratyphoid Fever
 Plague
 Pneumonia (Acute Influenzal)
 Pneumonia (Acute Primary)
 Poho-encephalitis (Acute)
 Puerperal Fever
 Puerperal Pyrexia
 Relapsing Fever
 Scarlet Fever or Scarlatina
 Smallpox
 Tuberculosis (all forms)
 Trench Fever
 Typhoid Fever
 Typhus Fever

Under the Factory and Workshops Acts, as has been noted above, every medical practitioner attending on, or called in to visit, a patient whom he believes to be suffering from anthrax, lead, phosphorus, arsenical, or mercurial poisoning is required under penalty to notify cases forthwith to the Chief Inspector of Factories at the Home Office, but notification of the list of infectious diseases mentioned in

the above alphabetical list has to be sent to the district medical officer, and the important thing to remember is that the notification should be made at the shortest possible period after the diagnosis. Among possible additions to the list which should be mentioned are measles and german measles, which are notifiable in many towns, while chicken-pox is frequently made the subject of notification during the prevalence of smallpox, so as to avoid the disaster of confusing the two conditions.

With regard to malaria and trench fever the onus is on the medical officer of health to report to the Ministry of Health the occurrence within the district of a case of either of these diseases, where there is a substantial reason to believe that the infection was contracted in the United Kingdom. The particular importance of this statutory order has gone by to a great extent, for it was a war measure, but the occurrence within any district of symptoms pointing to either condition should be made known to the medical officer of health as quickly as possible so that effective measures may be taken to prevent the spread of the infection.

The Public Health Regulations as regards tuberculosis have been recently tightened up in order to make the number of notifications recorded more in approximation with the deaths registered. Points to be remembered here are that notification made after the death of the patient is not considered a formal one, entitling the practitioner to a fee, and that the tuberculosis officer is enjoined to notify every case in which he diagnoses tuberculosis, unless he ascertains that this procedure has been followed by the practitioner. The local authority may ask for an explanation from the practitioner where there is *prima facie* evidence of neglect to notify cases of tuberculosis.

It is noted in the valuable text-book on "Public Health" of Prof E W Hope and Dr C O Stallybrass that most education authorities impose on the head teachers of schools the duty of reporting to the medical officer of health any cases of infectious disease that come under their

notice, while it is the experience in Liverpool that many cases which have not been medically attended are in this way brought to the notice of the medical officer of health—in other words, there has been a default in notification procedure Practitioners should never forget that the first condition for preventive action against disease to be taken by the local authorities is founded on compulsory notification

(2) UNDER THE INSURANCE ACT AND REGULATIONS THEREUNDER

Practitioners are required to furnish certificates to insured persons who are too ill to follow their occupations Such certificates are required by the Approved Societies to determine the question of the insured person's title to sick benefit The weekly payment is ordinarily made on these certificates, hence their importance to the societies The certificates have to be given in accordance with the Medical Certification Rules The printed form must be signed by the practitioner in his own hand, and must be given to the patient at the time of the examination, or within twenty-four hours of that examination Each certificate contains a statement that the patient has been examined, though to most practitioners it would appear unnecessary to state this The societies insist further that a separate examination shall be made before a fresh certificate is given There are six authorized certificates used in insurance practice, being Initial, Intermediate, Special Intermediate, Intermediate Convalescent, Final and Special Final Certificates, each with its own peculiarity and procedure In addition to these there is a form of certificate known as the "vague" certificate, in which the "specific disease" or bodily or mental disablement is not stated in exact terms because a clear, concise statement of the disease is likely to affect the patient's recovery or to inflict unwarrantable injury on him When this form is used the practitioner is required to inform the society that he has given the exact information to the regional medical officer,

who in turn assures the society that they may rely on the certificate as a safeguard in paying sickness benefit

From this it will be seen that the system of certification under the Insurance Act is complicated and full of pitfalls, but when it is realized that the total amount annually distributed in sickness and disablement benefits in Great Britain mainly on the evidence of the insurance practitioners' certificates is over £11,000,000, the necessity for a strict supervision becomes clearer. The certificate is a statement of facts and the signature of the practitioner is a guarantee that the statement may be relied on as truthful. The giving of a certificate of incapacity for work to an insured person is not a mere formality, and misleading certificates are regarded by the Ministry in a very serious light. Penalties from £5 to £50 have been inflicted on insurance practitioners convicted after official inquiry of giving false certificates. The Department, in cases where gravely misleading certificates have been issued, have reported the facts to the General Medical Council.

Fuller information will be found in Chapter XII

(7) OLD AGE PENSIONS ACTS

No forms of medical certificate appear to be prescribed by these Acts. The Warning Notice would cover the following points where medical opinion might conceivably be expressed

(1) Evidence of claimant's age

The second schedule to the Old Age Pensions Regulations of 1921 instructs pension officers, when investigating claims, to have regard to certificates of birth, baptism, etc., and "any other evidence which appears sufficient for the purpose"

(11) Evidence of blindness

The second schedule similarly instructs pension officers to have regard to "any other evidence" (in addition to the certificates of approved schools for the blind, approved workshops for the blind, etc.), where pensions are claimed under the Blind

Persons Act of 1920, which allows an old age pension at the age of 50 if the claimant is "so blind as to be unable to perform any work for which eyesight is essential"

(iii) Evidence of incapacity

The 1921 Regulations provide that where pensioners or claimants are suffering from mental or other incapacity, applications may be made to the local pension committee for the appointment of a representative to receive any sums on behalf of the person under such disability

Possibly in some or all of these cases medical certificates might be accepted as material evidence

(k) MERCHANT SHIPPING ACTS

Medical practitioners may have the duty of certifying to an emigration officer that the medical stores of an emigrant ship are "sufficient in quantity and quality," or that none of the steerage passengers or crew of an emigrant ship "appear to be by reason of any bodily or mental disease unfit to proceed, or likely to endanger the health or safety of the other persons about to proceed in the ship" (see Merchant Shipping Act of 1894, ss 300 (4) and 306 (1) (a))

Under the Distressed Seamen Regulations of 1921 (made by virtue of s 40 of the Merchant Shipping Act of 1906), the proper authority may discontinue relief to a seaman if satisfied by medical certificate or otherwise that the seaman is fit to work

No special forms of certificate appear to have been prescribed by Parliament or the Board of Trade

(l) IN CONNEXION WITH SICK BENEFIT, INSURANCE AND FRIENDLY SOCIETIES

Various provisions as to certification in connexion with sickness benefit have already been mentioned, but there are organizations giving sick benefit outside the National Insurance Act where the signed testimony to sickness of a

qualified medical practitioner may be required. The following may be given as an example of the many and various directions where the medical certificate may be sought from a practitioner.

Under Section 102 of the National Health Insurance Act of 1924 (superseding Section 68 of the 1911 Act) an insured person in receipt of sickness benefit may be protected against proceedings for ejectment or for the recovery of rent and against distress or execution upon his goods and chattels if the medical practitioner attending him certifies that the proceedings or the levying of distress would endanger his life. Certificates under this section are of limited duration and are subject to renewal. It is open to the other party in the proceedings to dispute the accuracy of the certificate and to obtain its cancellation or modification by the county court registrar.

(m) FOR PROCURING THE ISSUE OF FOREIGN PASSPORTS

Registered medical practitioners are among those who are privileged to vouch for those desiring passports, and it need hardly be said that they should not act as referees in this way unless fully assured of the facts to which they testify.

But apart from this, passports and visa regulations sometimes require evidence of health. These requirements vary from country to country and from time to time. The annual Foreign Office List summarizes the requirements of particular countries. Thus persons intending to travel second and third class to the Argentine must produce to the Consul certificates of medical and industrial fitness, blank forms of certificate should be obtainable from the steamship companies. Amongst other instances, vaccination and health certificates are required of persons proceeding to Ecuador, and tourists and visitors to Estonia must produce letters of reference or health certificates. Consulates should be consulted on the question whether a particular form is prescribed, but applicants for these certificates have usually secured the necessary forms.

(n) ATTENDANCE IN COURT

These certificates relate to parties, witnesses or jurors in both civil and criminal actions. No special form has been prescribed.

A medical certificate of unfitness to appear in court, submitted on behalf of an accused person awaiting trial at Lewes Assizes in 1926, was ignored by the court as the person was actually present in court. The incident was discussed in the Court of Criminal Appeal, where it was ruled that the question of postponing the trial upon medical evidence of the ill-health of one of the defendants was a matter for the judge and not an issue of the case.

The Sex Disqualification Removal Act of 1919 enacts that persons are not to be exempted by sex or marriage from liability to serve as jurors, but provides that rules of court may be made exempting from attendance as jurors any women who are for medical reasons unfit to attend (9 & 10 Geo 5, c 71, s 1). Under this provision Rules of the Supreme Court (dated October 15, 1920, and forming Rule 9A of Order XXXVI of the R S C) set forth that every jury summons served upon a woman must specify that she may apply to the summoning officer for exemption on the ground of "pregnancy or other feminine condition or ailment," and empower the under-sheriff or other person whose duty it is to form the jury panels to exempt at his discretion any woman summoned as juror "if he is satisfied by medical certificate or otherwise that on account of pregnancy or some other feminine condition or ailment she is, or will be, unfit to serve."

Corresponding provision is made by County Court Rules, and by the Women Jurors (Criminal Cases) Rules, both also made in 1920.

These provisions relate to England only, but similarly worded rules have been made for Scotland.

(o) IN CONNEXION WITH NAVAL AND MILITARY MATTERS

In so far as this Warning Notice applies to officers in the Services, their duties in respect of all certificates and reports

are carefully laid down in their own regulations, but certain certificates have to be given by civil practitioners for use by Service authorities, and the warning is to the effect that the same care must here be exercised as in the other circumstances detailed. The subject of certification must be seen and examined by the certifier personally. Attention must be paid to the wording of the form in order that what it requires may be fulfilled, and the document must, of course, be dated

TWO IMPORTANT POINTS

It will be seen how very important it is from the public point of view that all conceivable care and accuracy should be displayed in the issuing of certificates, and there are two further points so obvious that they find no place in the admonitions of the General Medical Council to the medical profession. They require every attention.

The first is that all certificate forms should be kept under conditions which will prevent their falling into the hands of unauthorized persons, that is to say, under lock and key. In a circular addressed to insurance committees the Minister of Health states that cases still come to light in which sickness or disablement benefit has been fraudulently obtained by means of forged medical certificates, the forms having been stolen from practitioners' surgeries. This warning is printed on the covers of the first batch of certificate books issued to practitioners when they first join the medical list, and on the first batch of books issued to all insurance practitioners at the commencement of each year. The Ministry of Health is the authority most concerned in the possible dissemination of forged certificates, and so many different documents may require signature in the course of professional life that the words of the Ministry should be kept in mind in respect of all books of certificates.

The second point requiring attention is the absolute necessity of filling up forms in a legible manner. It is not only in the matter of prescriptions that legitimate complaints have been received in regard to the calligraphy of the medical

profession , many officials have been put to considerable trouble to avoid errors that might have followed upon misinterpretation of handwriting, and sometimes actual trouble has occurred. Signatures should always be written , printed signatures encourage fraud, and on this account have been rejected by County Court judges when produced in the course of litigation

CHAPTER XIX

COVERING

Unqualified Assistants—Relations with Unqualified Persons—Case of the late Dr Axham—Ancillary Medical Service—Uncertified Midwives and Covering

THE professional offences which the General Medical Council has particularly condemned are set out in Chapter XIV, and are now to be considered. The first disciplinary caution of the Council, against laxity in respect of the high responsibility of signing medical certificates, has been dealt with in the previous chapters.

The second caution is against the improper employment of assistants in medical practice, the association between the two offences being that in days not long gone by most of the bad abuses which arose in regard to medical certificates had a connexion with the circumstances in which practitioners were assisted in their professional work by non-qualified persons. The warning of the Council may seem to-day an anachronism, but, although the unqualified assistant has ceased to exist, there is no doubt that he would reappear if his employment were not forbidden. And he would do so in a more dangerous form. Thirty and forty years ago he had many qualities enabling him to discharge convenient and even valuable work when he was properly used, whereas in a reincarnation he would have no justification, and his substitution in many junctures for the qualified practitioner would be, in the stern language of the General Medical Council, "fraudulent and dangerous."

UNQUALIFIED ASSISTANTS AND COVERING

These unqualified assistants were too frequently left in sole charge of medical practices, although possessing little or no professional knowledge, and so greatly was this

custom abused that in 1893 the General Medical Council passed a resolution to the following effect "that the Council record on its Minutes for the information of those whom it may concern, that charges of gross misconduct in the employment of unqualified assistants, and charges of dishonest collusion with unqualified practitioners, in respect of the signing of medical certificates required for the purposes of any law or lawful contract, are, if brought before the Council, regarded by the Council as charges of infamous conduct under the Medical Act "

This pronouncement was followed in 1897 by the following Warning Notice

Whereas it has from time to time been made to appear to the General Medical Council that some registered medical practitioners have been in the habit of employing as assistants in connexion with their professional practice persons who are not duly qualified or registered under the Medical Acts, and have knowingly allowed such unqualified persons to attend or treat patients in respect of matters requiring professional discretion or skill, and whereas in the opinion of the Council such a substitution of the services of an unqualified person for those of a registered medical practitioner is in its nature fraudulent and dangerous to the public health, the Council hereby gives notice that any registered medical practitioner, who is proved to have so employed an unqualified assistant, is liable to be judged as guilty of "infamous conduct in a professional respect," and to have his name erased from the Medical Register under the 29th section of the Medical Act, 1858

Further, in regard to the practice commonly known as "covering," the Council gives notice that any registered medical practitioner, who by his presence, countenance, advice, assistance, or cooperation, knowingly enables an unqualified or unregistered person (whether described as an assistant or otherwise) to attend or treat any patient, to procure or issue any medical certificate or certificate of death, or otherwise to engage in medical practice as if the said person were duly qualified and registered, is liable to be judged as guilty of "infamous conduct in a professional respect," and to have his name erased from the Medical Register, under the said enactment

But the foregoing notices do not apply so as to restrict the proper training and instruction of bona-fide medical students or the legitimate employment of dressers, midwives, dispensers, and surgery attendants, under the immediate personal supervision of registered medical practitioners

The General Medical Council, in pointing out that the employment by any registered medical practitioner in connexion with his professional practice of an assistant who is not duly qualified or registered brings with it a liability to erasure from the Medical Register, goes into detail, assuming that unqualified persons would be employed to "attend, treat or perform operations upon patients in respect of matters requiring professional discretion or skill" From this the assumption may be made that an assistant can be employed legitimately as a dresser, dispenser or dispensary attendant working under personal supervision Any other use of the unqualified assistant is in the opinion of the Council a fraudulent act, inasmuch as the public may well believe that the ministrations are those of a duly qualified practitioner, and there is danger to the public health for the same reason

The Warning Notice goes on to say, in connexion with covering, that any registered practitioner who "by his presence, countenance, advice, assistance, or co-operation knowingly enables an unqualified or unregistered person to attend, treat or perform any operation upon a patient in respect of any matter requiring professional discretion or skill . is liable to have his name erased from the medical register" Further, the practitioner is warned that no unqualified assistant, or, indeed, unqualified person, can issue legally any of the certificates and notifications previously described, a point which appears to have been occasionally overlooked Even where an assistant has been legitimately employed in book-keeping, in managing correspondence, or in attending to the minor duties of the surgery, he has been known, while filling up the body of these documents, to add the signature Having regard to the wording of the documents it is curious that such an error should ever have to be noted, and still more that it should persist

RELATIONS WITH UNQUALIFIED PERSONS

Concerning the covering of unqualified persons, it is laid down by the General Medical Council that the qualified

practitioner is liable to penalty if he works in association with an unqualified person, assisting him to treat patients or to perform operations, one form of assistance mentioned being the administration of anæsthetics

Of the disciplinary procedures against members of the profession convicted of unprofessional behaviour two are found especially difficult of comprehension by the public, and yet the actions taken are taken entirely in the public interest. The offences, whose punishment is most frequently commented upon adversely by the lay press, may be grouped under improper advertisement (see Chap XX) and improper association with unqualified practitioners. It is not seen that the measure of impropriety in either case must be estimated by the Council in accordance with its public duties, but *also* with attention to professional reasons, the force of which will not appeal always to the layman, so that if a particular case attract the attention of the lay press certain newspapers invariably assume that hardship has been done, while ill-informed persons, often with much ability, seem to delight in describing the Council as tyrannous. Further, as medical men themselves read daily papers, and meet the promoters of the agitations, the reiterated criticisms of the Council may have their effect upon them, if they are not conversant with the actual facts. When this occurs the public criticisms of the Council become more bitter, because it appears that the professional standards employed to protect the public do not give satisfaction to all professional men, in short, those who regard the maintenance of professional standards as inimical to the public welfare view with satisfaction what they regard as a division of medical opinion.

While far more sympathy is manifested by the lay press for the medical man who is removed from the professional roll for advertisement, it occasionally occurs that the circumstances where a practitioner loses his professional status for association with unqualified healers attract public attention. This happened, for example, in the case of the late Dr Axham, because the unqualified man with

whom he entered into relations had received a knighthood while Dr Axham's punishment for having entered upon those relations had not been relaxed. If, however, the story is considered from the beginning, it will be seen, first, that the Council had little or no option when they removed Dr Axham's name from the Register, and secondly, that the method of restoration does not depend primarily upon the Council. Under the Medical Act of 1858, the Council is enjoined, at its discretion, to delete from the official roll the names of medical men whose conduct in professional respects is derogatory to accepted standards. To ensure that medical men shall not err through ignorance, the Council issues warnings, and among these is the one now under consideration, pointing out that association by a qualified medical man in medical practice with an unqualified person would render the medical man subject to penalty. Dr Axham was associated in practice with Sir Herbert Barker—then Mr Barker—who treated patients without possessing statutory medical qualifications, and the association was quite open. The circumstances were brought before the General Medical Council by the Medical Defence Union, and the Council finding the offence proven—it was not denied—decided to remove Dr Axham's name from the Register unless he terminated his arrangement with the unqualified man. Dr Axham then preferred to maintain the existing position, but later was anxious to re-obtain registration. He was of advanced age, and was no longer committing the offence for which he had to answer. The position of the Council, however, is that only qualified persons can be entered on the Register. Now Dr Axham had lost his qualifications, for his diplomas were taken away from him by the Royal Corporations which had previously granted them in response to examinations. Unless and until the diplomas were restored the Council had not the power to act in the way insisted upon in some quarters. It can be understood readily enough that this point might not be clear to the laymen who attempted to advance the cause of Dr Axham by abuse of the General Medical Council,

but it was a little surprising to find medical men equally ill-informed as to the Medical Acts and as to the constitutional position and duties of the Council

On the general need of action by the disciplinary body of the profession against covering there cannot be two opinions, for if a man who is not qualified can practise as a doctor through association with one who is qualified, the Register ceases to protect the public against irregular practice. Again, to the question of whether a particular unqualified person can have exceptions made in his favour there can be but one answer—any exception would frustrate the whole disciplinary procedure

Ancillary Medical Service

Medical men who are careful to help in the maintenance of professional standards, and who are rightly jealous of the privileges conferred upon them in return for a strenuous and lengthy training, have many of them recognized, and recently with increasing force, that there are certain quasi-medical services, ancillary to scientific medicine, which are rendered properly by those without medical qualifications. The public can take advantage of such services, if that is desired, in a way that is of the greatest use to them, if the services are given upon medical advice as the need arises. There is then no doubt that the public obtains the assistance in response to medical advice, that persons who do not need the treatment are not mulcted of fees, that cures for non-existent conditions are not bruited abroad, and that specifics for cancer are not made the medium of false hopes. Lastly, real benefit is obtained through the rightful exercise of special attainments

UNCERTIFIED MIDWIVES AND COVERING

The last section of the Warning Notice deals with the offence of extending cover to uncertified midwives, and the words employed in the Notice are so full and clear that they require little comment, while we doubt if any practitioner to-day will be misled by carelessness to commit

the offence. Ten years ago, however, the action of certain practitioners in their relation with uncertified midwives was brought to the notice of the General Medical Council by the Central Midwives Board, which latter body testified to the occurrence of certain abuses which were found to occur with some frequency. In several disciplinary cases which the General Medical Council had at the time to consider, it had been shown that, notwithstanding the provisions of the Midwives Act, 1902, and the Midwives (Scotland) Act, 1915, uncertified women had been in effect enabled to defy the law through the countenance, assistance, or connivance of qualified medical practitioners. Under those Acts uncertified women are prohibited from habitually and for gain attending women in childbirth, save under the direction of a qualified medical practitioner. The offence took the form of the practitioner paying perfunctory visits to confinement cases which were attended by an uncertified woman, and then signing certificates and kindred documents giving colour to the pretension of the uncertified woman, as acting under the direction of a qualified medical practitioner. It was recognized by the General Medical Council in discussing these cases that, if a medical man was summoned in an emergency and found that the patient was being attended by an uncertified woman, his duty would be discharged by notifying the circumstances to the local authority. He laid himself open, however, to the charge of covering if he concealed the facts from the local authority and filled up certificates purporting to show that he was in charge of the case.

CHAPTER XX

ADVERTISING AND CANVASSING

Signed Contributions to the Public Press—The Attitude of the General Medical Council—Canvassing

THE sixth section of the Warning Notice is headed "Advertising and Canvassing," and the wording is applicable to all procedures under which publicity may obtain for a particular medical man an unfair advantage over his professional brethren, but the obvious offence referred to in the notice under the word "Advertising" is that of procuring improper publicity through the medium of the lay press (see Chap XIV, p 133)

ADVERTISING

The question of signed contributions by medical men to the public press has recently acquired considerable importance. There is a widespread desire on the part of the public to receive sound medical information through the medium of their newspapers, and the editors of those designing to meet the demand, which is a natural one, cannot understand the reluctance of medical men to satisfy it. Especially neither do the editors nor their public understand the reasons why the General Medical Council have in certain circumstances made of the writing of signed articles in lay papers "infamous conduct in a professional respect." When practitioners have incurred the censure or punishment of the Council for their contributions to lay papers the real situation has not been appreciated by the public and not always by the medical profession. Reference to the Memorandum of the Registrar (see Chap XIII) makes the view of the Council on the matter more clear than does the wording of the Warning Notice. The Memorandum (see p 128) says "The character of the advertising varied. In some cases articles were inserted in the press, either by

the practitioner himself or through the medium of complaisant journalists, affirming directly or by implication the superior methods of treatment of a practitioner, who desired for gain to attract patients to himself at the cost of his self-respect and the respect of others. If this procedure were unchecked, the practitioner who had fewest scruples, in praising himself and his wares, would reach the widest public, and extend his practice without any guarantee that his merits were in fact superior. It was discreditable to his profession, and contrary to the public interest, that a qualified man should thus adopt the methods of the unqualified self-advertising and self-praising practitioner of medicine or surgery. Accordingly the Council warned the profession against conduct of that kind, and, where a formal and duly attested complaint of such conduct is received, it holds an inquiry into the alleged facts. When the inquiry elicits evidence of deliberate bad faith, or of wilful exploitation of the public for gain, the offence of 'unprofessional advertising' is naturally held to be aggravated."

No medical man has been subjected to rebuke or penalty by the Council for giving sound medical information, the penalty has always been incurred through the injudicious self-advertising nature of the article or articles, resulting in possible deception of the public. As more and more medical men are asked to supply medical information to the lay press, owing to the increasingly intelligent interest of the public in medical questions, every practitioner should understand the position.

Signed Contributions to the Public Press

The fundamental difficulty in the signed article may arise from the character of the demand for information. Is this demand made by the public, and is its satisfaction directed towards the dissemination of knowledge that would be really useful on public grounds? Or does the demand originate with the journal which considers that ventilation of a particular topic would make attractive reading? The character of the demand makes a vast

difference in the onus laid upon the medical profession to be communicative. Where the public desires spontaneously information for its useful guidance the difficulty of supplying the instruction and advice, signed or unsigned, ought not to be insuperable, and it must be admitted that articles have more influence above a signature. It is safe to-day to believe that medical lessons or advice of a general sort can be set out in a newspaper in a form that will be useful, because comprehensible, to educated persons, and the advantages of publishing such articles with a direct medical impress would be very great. There seems to be a general consensus of opinion up to this point. The addition of an individual signature ought to be unnecessary. But—and therein lies most of the trouble—in the eyes of editors of most newspapers the medical signature is of preponderating importance. This is partly due to the apprehension that readers may think that articles purporting to be written by a medical correspondent are not the work of a medical man. They sometimes are not, but there are papers which command rightly the confidence of their audiences, whose editorial statements as to the provenance of an article would always be accepted, and it would be a good thing if they would come to see that the insistence upon a signature deprives them of valuable material.

The editorial belief that the name of a medical man, particularly if he has some conspicuous professional position, is the testimony which the public require to the accuracy of any views set forth on any medical question is, however, well founded. It would be very convenient both for the medical profession and for editors if it could be got rid of. For under its influence any editor, full of wisdom and altruism, may be led to act exactly as an editor possessing neither of these qualities in marked manner would act—namely he may assume what the policy of a medical article ought to be, and attempt to find a man to write in support of the assumption. If he selects one who holds the necessary views, and who in the eyes of his professional colleagues has a claim to be an authority—one in fact

who really knows—it will be often the case that the medical man will decline the commission. If he should decline the danger-point is reached. It is no longer a real authority who is sought for, but someone who in the eyes of the public is assumed to be full of medical wisdom. His name is known, and the more articles he signs the wider is that knowledge. Such a man must write in vague and general terms, he is without precise information, takes refuge in generalities, and as a rule makes up by the violence of his generalities for the absence of his precision. Undoubtedly some editors like these articles, and the policy of publishing them is justified by the melancholy fact that a large public also likes them, but they do not represent any dissemination of medical information that is valuable to the public, and it is their constant appearance which prevents those who at the proper time and in the proper way could issue valuable teaching, allowing their signatures to appear. Thus the public is stirred to apprehension, without receiving definite instruction, the net result being distrust of the man who is treating them from personal acquaintance with their individual cases.

The Attitude of the General Medical Council

The signature by medical men of articles in the press affords, therefore, many points of interest to the General Medical Council, whose pronouncement should be in the mind of every practitioner before he makes a public communication. The publication in the press of articles on medical subjects by practitioners has not been condemned by the Council, unless it has been proved that the articles come under the terms of the Warning Notice of the Council against advertising, or are otherwise of an objectionable nature. The responsibility rests with the Council to decide whether any articles signed by a medical man in the press do constitute advertising or are objectionable, and when a practitioner, with due formality, is asked to explain his conduct, the issues are heard in public (though not the deliberations of the Council upon them), the im-

peached man being present, and, if he chooses, being represented by counsel or solicitors. A judicial assessor assists the Council in regard to any points of law and indicates the legal weight of the evidence, so that all precaution is taken against hasty or improper action. Some critics of the Council have certainly not been aware of the safeguards. A report of the British Medical Association upon the contribution of articles on medical matters to the press held that to do so was legitimate, indeed that it might be advisable for medical practitioners, who could speak with authority on the question at issue, to contribute to public discussions, but stated that discussions on disputed points of pathology or treatment should be avoided. If it were possible for a medical article to be at once devoid of reference to pathology, unconcerned with treatment, and at the same time to be the sort of article which the public press seeks, the matter would be simple. But the articles which medical men are begged to supply to the press almost always deal with pathology or with treatment or both.

The General Medical Council cannot possibly pronounce all signed articles in the lay press which have pathological or therapeutical references to be unethical, and the British Medical Association cannot possibly say that because an article is silent on pathology and therapeutics it contains no element of professional offence. The General Medical Council is concerned with preventing the appearance of articles of a self-advertising or objectionable nature, and the articles which will lead directly to penal interference are those where the self-advertising takes the form of giving advice on disputed pathological questions from an assumed superiority of knowledge. Many articles which are not objectionable, in that they do not mislead the public scientifically, may bring their authors before the public in a manner that their colleagues think unfortunate, the author may be acquitted of self-advertisement but still secure a measure of publicity in an undesirable way through his action in writing the articles. This is why a practitioner whose name comes before the public through the announcement

of simple hygienic lessons is accused of self-advertisement; he does not offend by pretending in so many words to superior individual knowledge, but the signing of the article confers that quality upon him, and it is the quality which the journal issuing his contribution would suggest that he possesses. He may be really doing good, but the inconvenience of his conduct is that, when another man does the same thing and in the other man's article direct advertisement can be detected, so that his name is removed from the official list of the profession, the public considers that an unfair difference of treatment has been meted out by the General Medical Council.

Everything that has been said concerning the signed article is applicable to articles which appear in the guise of an interview for the purposes of publication, so that it is imprudent of a practitioner, who knows that his words are to be used in the public press with his own authority, not to demand a proof of the article before publication.

Conclusions

The practitioner who desires to sign an article in the press should feel sure that what he has to say needs saying, that he has the right experience from which to say it, and that he is not introducing to an audience, unable to weigh, from technical knowledge, the theories, deductions, or opinions which he could not support among his colleagues. It is an act of vanity, which may have mischievous consequences, to promulgate personal views where they are unnecessary and where they cannot be challenged. The practitioner who accepts an invitation to contribute a medical article to the press, having similar considerations before him, should feel sure that the public will gain by the information which he has to give, and that it has been sought from him because he is admitted by his colleagues to be an authority. And thereafter he should remember that, if he gains in public esteem, he may none the less be held to have broken the spirit though not the letter of medical ethics. This is a consequence following either

upon the right or the wrong conduct, and the fact that it may occur in either case shows again that the situation is not simple

CANVASSING

With regard to canvassing, it seems almost unnecessary at this time of day to lay any stress on the reprobation by the General Medical Council of the employment of a lay agency for the purpose of obtaining patients. The circumstances in which this was occasionally done, either out of carelessness or corrupt motives, have largely disappeared with the disappearance of club practice, and of the lay associations for the exploitation of medical employees. There was a time when the medical men who received small salaries, either in the form of capitation fees or incomes, towards which gratuitous house rent contributed, found themselves advertised in their neighbourhoods as part of the material advantages offered to the public, their particular services being categorized as one of the benefits that would accrue to the public who enrolled themselves in the list of subscribers. The abuse, bad enough in itself, sometimes led to imitation, other practitioners, seeing that their colleagues were being acclaimed by some club or association as particularly efficient, riposted by sending out circulars indicating at any rate when and where they themselves were to be found. These practitioners, sometimes seriously injured men, unable to shelter themselves behind the actions of other people, were easily recalled to a right standard of professional behaviour, but those whose merits were brought by lay committees to the notice of the public formed more difficult cases, particularly as in some of the instances the offence had apparently occurred without the practitioner's knowledge and was not only trivial but harmless. As, however, the more flagrant examples were dealt with, and as a better appreciation of the situation led to an alteration of procedure among clubs and associations, the abuse was fast disappearing when the arrival of the panel system closed the chapter. But although the warning of the General Medical Council is rather a

reminder of what has happened than of what is likely to happen, it is not difficult to imagine occasions when a practitioner might be invited to sanction a publicity secured for him by outside agency, which would have the result of unduly exalting him above his fellows. It is well that this possibility should be borne in mind.

Some General Points

Under the head of canvassing for public support certain proceedings have been definitely reprobated by medical men, apart from the use of flamboyant door-plates and the issue of professional cards.

Circulars regarding special treatment should be issued to medical men only, and then with discretion. This well-known sentiment has been assumed to criticize the issue of medical information to pharmaceutical chemists, but, while the display of a doctor's professional card in a chemist's establishment would be rightly objected to, there are directions in which cooperation between the chemist and the practitioner may be very helpful to the patient, and relations of this sort are promoted by the interchange of experience—they are not to be confused with improper arrangements between a doctor and a chemist for exploitation of the public.

Changes of professional address should be announced discreetly, and addresses should not be exposed in clubs, institutions, or hotels, it is sufficient that the address of the medical practitioner whom the management trusts should be available on inquiry.

Testimonials should not be circulated to the public. Those sought for by lay bodies having the responsibility of making appointments, are naturally of a complimentary character, and occasionally receive reproduction in the lay press. When this occurs it forms as a rule a strong example of the harm that can be done by injudicious friends, as far as a candidate for a post can prevent such publicity he will be wise to do so, for by it his chances of success may be jeopardized.

CHAPTER XXI

THE SALE OF POISONS AND THE DANGEROUS DRUGS ACTS

Home Office Memorandum—General Provisions—Penalties and Offences—Recent Regulations

THE opinion of the General Medical Council in respect of the offence of improper sales of poisons by doctors has close reference to the cautions concerning covering and the employment of unqualified assistants. The practitioner is warned of his responsibility if he undertakes the sale to the public of scheduled poisons or preparations containing them. Such sale must not be left in the charge of assistants who are not legally qualified for the duty, namely, who are not either qualified medical practitioners or qualified pharmacists.

The Act of Parliament regulating the use of dangerous drugs was in its first shape a measure prepared to give effect to the International Opium Convention, which had been signed as far back as 1912 at the Hague. The Bill became law in September 1920, and under it power was given to make regulations to control the manufacture, sale, possession and distribution of certain drugs. Many minor regulations and amendments came into force, in May 1923 the Dangerous Drugs and Poisons Amendment Act was passed and in March of the same year a memorandum on the duties of Doctors and Dentists under the Act of 1920 was issued by the Home Office. Further, under the Defence of the Realm Act, during the War many orders were made dealing with the sale of opium and cocaine similar in character to those of the Dangerous Drugs Act, indeed the War Emergency Regulations dealing with dangerous drugs and narcotics worked so smoothly and satisfactorily that they may be said

to have paved the way to the issuing of the Dangerous Drugs Regulations of 1921. The practitioner will be familiar with the constant emendation of these Regulations as circumstances dictate them.

A Memorandum was issued by the Home Office in July 1923 as to the Duties of Doctors and Dentists under the Dangerous Drugs Acts, 1920 and 1923. By the Acts and the Regulations made under them (enumerated below),¹ certain obligations in regard to the giving of prescriptions and keeping of records are stated to devolve on medical and dental practitioners, and the Home Office has decided that the needful inspection, in order to ensure the 'due fulfilment of the obligations, would be best carried out in England and Wales by Medical Officers of the Ministry of Health, and in Scotland by Medical Officers of the Scottish Board of Health. The following is a short statement of the main provisions of the Acts and Regulations in which doctors and dentists are specially concerned.

THE HOME OFFICE MEMORANDUM

I. GENERAL PROVISIONS

(a) *Drugs Involved*

- 3² The drugs to which the Dangerous Drugs Acts apply are
raw opium ,
and

medicinal opium ,³

cocaine and ecgonine and their salts ,

morphine and its salts ,

diamorphine (heroin) and its salts , and

any preparation, admixture, extract or other substance containing $\frac{1}{2}$ per cent or more of morphine or per cent or more of cocaine, ecgonine or diamorphine

Collectively referred to in this memorandum as dangerous drugs

Application of the Acts to coca leaves and Indian hemp is prospective, as defined in Section 1 of the 1925 Act

¹ The Acts and the Regulations, together with any subsequent amendments, may be obtained through any bookseller or direct from the Stationery Office

² In the Memorandum, paragraphs 1 and 2 comprised the introduction

³ Medicinal opium is defined in the 1920 Act as raw opium which has been artificially dried. This definition was prospectively repealed and replaced by the 1925 Act. When the latter Act takes effect, "medicinal

The percentage in the case of morphine is calculated as in respect of anhydrous morphine

The percentage of a drug contained in a solution is to be calculated on the basis of the number of grammes of the drug contained in 100 millilitres of the solution

4 No person is allowed to bring into, or take out of, the country¹ any of the drugs unless he is licensed by the Home Secretary, and no person is allowed to be in possession of the drugs (subject to the exceptions named in the next paragraph) unless he is licensed or otherwise authorized for the purpose, or unless the drug has been supplied for his use by a medical practitioner or in accordance with a medical or dental prescription

(b) *Preparations Excepted*

5 It should be noted that the following preparations, though they come within the Acts, are specially exempted from the Regulations, and may be bought and sold in Great Britain in the same way as ordinary "poisons" under the Pharmacy Acts

Cereoli Iodoformi et Morphinae B P C	Pil Hydrarg c Creta et Opii B P C
Emp Opii B P 1898	Pulv Cretae Aromat c Opio B P
Lm Opii B P	" Ipecac Co B P (Dover's Powder)
" Opii Ammon B P C	" Kino Co B P
Pasta Arsenicalis B P C	Suppos Plumbi Co B P
Pil Hydrarg c Opio B P C	Tablettae Plumbi c Opio B P C
" Ipec c Scilla B P	Ung Gallae c Opio B P
" Plumbi c Opio B P	" Gallae Co B P C
" Digit et Opii Co B P C	

It should also be noted that the following preparations do not come within the Dangerous Drugs Acts as yet, though changes are in prospect

Any preparation containing less than $\frac{1}{2}$ per cent of morphine or $\frac{1}{16}$ per cent of cocaine, ecgonine or diamorphine. Thus, any mixture containing in each drachm not more than 11 minims of Tr Opium, or 15 minims of liquor morphinae hydrochlor, or 16 minims of opium" will mean "raw opium" which has undergone the processes necessary to adapt it for medicinal use in accordance with the requirements of the British Pharmacopœia, whether it is in the form of powder or is granulated or is in any other form, and whether it is or is not mixed with neutral substances

¹ Includes Great Britain, Northern Ireland, and the Isle of Man, but excludes the Irish Free State and the Channel Islands

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liquor morphinæ acetat, would be unaffected by any of the provisions of the Regulations

(c) *Medical Practitioners and Dentists are Authorized Persons*

6 Any duly qualified medical practitioner or any registered dentist is authorized by the Regulations to be in possession of dangerous drugs and to supply them by personal administration, or by administration under his direct supervision, and a medical practitioner (but not a dentist) may dispense dangerous drugs for the use of his patients. A medical practitioner (but not a dentist) may also be in possession of raw opium for use in the compounding of medicines, but raw opium may not be supplied to a patient.

In all cases these authorizations are qualified by the words, "so far as is necessary for the practice of his profession". The words underlined are important. a doctor or dentist may not have or use the drugs for any other purpose than that of ministering to the strictly medical, or dental, needs of his patients.

7 Subsequently throughout this memorandum "doctor" is to be read as meaning a medical practitioner whose name is on the Medical Register, and "dentist" as a dental practitioner whose name is on the Dental Register.

8 In what follows, it should be noted that Parts II, IV, V, and VI apply to all doctors and dentists, Part III only to doctors that dispense.

II REGULATIONS APPLICABLE TO ALL DOCTORS AND DENTISTS

(a) *Prescriptions*

9 The following remarks apply to all prescriptions for medicines containing a dangerous drug in sufficient strength to come within the Act, with the exception of the preparations mentioned in para 5 above. (N B —Raw opium may not be supplied on a prescription or dispensed to a patient.)

10 The Home Secretary has power to prescribe an official form to be used for such prescriptions, but he has not at present done so.

11 Under the Regulations the prescription

- (a) must be in writing and be dated,
- (b) must be signed with the *usual signature* of the prescribing doctor or dentist,
- (c) must bear the *address* of the prescribing doctor or dentist (except in the case of prescriptions issued for National Health Insurance purposes on the official form),
- (d) must state the name and address of the patient,
- (e) must state the total amount of the drug to be supplied on the prescription.

12 Dentists may give prescriptions for dental treatment only, and in addition to complying with the above requirements, they must mark the prescription "For local dental treatment only"

13 A chemist may only dispense the prescription either (a) if he is acquainted with the prescriber's signature, and has no reason to doubt the genuineness of the prescription, or (b) if he has taken reasonably sufficient steps to satisfy himself that the prescription is genuine. The prescription has to be retained by the chemist by whom it is dispensed (except in the case of prescriptions issued for National Health Insurance purposes on the official form) and he is only allowed to dispense it once, unless the doctor or dentist specially directs in the prescription that it may be dispensed twice or three times (but not more than three times) at intervals which he specifies. In no case is the chemist allowed to dispense it more than three times in all.

14 A doctor or dentist who gives, and a chemist who accepts and dispenses, a prescription not drawn up in every particular in accordance with these Regulations, commits an offence against the Act.

15 The Home Secretary desires to impress as strongly as possible on doctors and dentists the importance of their observing these requirements strictly when giving a prescription. Any irregularity on the part of the doctor or dentist may lead to delay in the patient obtaining the medicine prescribed for him, and it is extremely unfair to the chemist that he should be placed in the position of delaying an important prescription and possibly offending the doctor or dentist, or committing a breach of the law. The Home Secretary has reason to believe that at the present time there are very numerous irregularities in giving prescriptions for the drugs, and representations have been made to him by chemists as to the difficult position in which they are placed, and the annoyance or resentment displayed by doctors and dentists in many cases at being asked to correct the irregularities of their prescriptions.

(b) Method of Obtaining Supplies of the Drugs

16 A doctor or dentist who requires the drugs for the purpose of his practice may obtain them from any person who has a general licence or authority under the Dangerous Drugs Acts to supply the drugs. All pharmacists who are lawfully keeping open shop in accordance with the provisions of the Pharmacy Acts are so authorized (except in the rare cases where the authorization has had to be withdrawn for offences against the Act), and all, or practically all, the established firms of wholesale chemists have also obtained licences from the Home Secretary to supply the drugs. In any case of doubt a doctor or dentist can always ascertain, by inquiry from the Home Office, whether a firm is authorized.

17 Sales to doctors or dentists (otherwise than on a prescription) must be made in accordance with the provisions of the Pharmacy Acts relating to the sale of poisons that is, the doctor or dentist (a) must either be known to the supplier (whether wholesale or retail) or be introduced by someone known to the supplier, and (b) must either sign the "Poison Book" in person or send a written and signed order, stating his name, address and the name and quantity of the article required. In the latter case the seller has to be reasonably satisfied as to the genuineness of the signature, and the qualifications of the purchaser, and, if the drugs are sent by post, must send them by registered post. Special provision is made for real emergencies, where the doctor or dentist is unable either to send a signed order in time, or to attend and sign the "Poison Book". In such cases the supplier may act on (say) a telephone message and send the drugs, provided that on delivery he receives from the doctor or dentist the signed order in exchange, or an undertaking that the signed order will be furnished within twenty-four hours. As the supplier has to be reasonably satisfied, before sending the drugs in this way, that there is a real emergency and that the signed order will be forthcoming on delivery or within the next twenty-four hours, doctors and dentists are recommended—in order to avoid any difficulty—to give the necessary explanation and assurance when ordering the drug. If the doctor or dentist fails to honour his undertaking or knowingly makes a false statement to obtain the drugs, he commits an offence.

18 It should be remembered that, as a supplier is only permitted to sell to duly authorized persons and within the limits of their authorization, a general responsibility rests upon him to satisfy himself before selling the drugs that the purchaser is authorized by the Regulations to have them.

19 If a messenger is sent by the doctor or dentist to take delivery of the drugs, the messenger must be given an authority in writing, signed by the doctor or dentist, to receive the drugs on behalf of the doctor or dentist, a chemist is forbidden to deliver drugs to a messenger not so authorized.

20 Doctors and dentists are advised to keep any dangerous drugs, when not in use, under lock and key, so far as possible. This is not actually required by the Regulations, but is obviously a desirable precaution.

21 A doctor or dentist who requires the drugs solely for administration to his patients by himself personally, or under his own direct personal supervision, is under no obligation to keep the records required by the Regulations as explained in Part III of this memorandum.

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III REGULATIONS APPLICABLE TO DISPENSING DOCTORS¹

22 Doctors who dispense or supply medicine² are under the obligation to keep the registers of purchases and supplies described below

(a) Register of Purchases

23 Separate registers, or separate parts of a register, are to be appropriated for each of the drugs The form in which the register has to be kept is as follows

Date on which supply received	Name of person, body or firm from whom obtained	Address of person, body or firm from whom obtained	Amount obtained	Form in which obtained

24 The correct entry in the register must be made on the day on which the drug is received or the following day, and an entry once made must not be cancelled, obliterated, or altered, any mistake must be corrected by a foot-note or marginal note giving the correct particulars and dated

(b) Register of Supplies

25 Similar registers, or parts of a register, must be kept for each drug "supplied" in the following form

Date of Supply	Name of person to whom supplied	Address of person to whom supplied	Authority of person supplied to be in possession of the drug ³	Amount supplied	Form in which supplied	Specify the ingredients of the prescription

¹ Part III does not apply to dentists, as a dentist may not himself dispense the drugs to patients

² The obligation would apply in the case of a doctor leaving a supply of any of the drugs with a nurse for administration to a patient during the absence of the doctor

³ Where, as will usually be the case, the supply is on the doctor's own prescription, it will be sufficient to enter the word "Patient" in this column

26 The entry must be made on the day on which the drug is supplied or the following day. The same rule as to mistakes and corrections applies as in the case of the register of purchases.

27 It is specially provided, however, by the Regulations, that if a doctor keeps a day-book in which he records particulars of any of the drugs dispensed by him to his patients, with the name and address of the patient and date of supply, he need only record in his register of supplies the date and the appropriate reference to the entry in his day-book.

28 A doctor who dispenses at more than one set of premises is required to keep a separate register or registers at each set of premises.

29 All records, including registers and day-books, must be kept for not less than two years from the date of the last entry therein.

IV OFFENCES AND PENALTIES

30 A doctor or dentist who obtains, or attempts to obtain, the drugs for a purpose not covered by his authorization, or who infringes any of the Regulations, commits an offence against the Act.

31 Offences may be tried either on indictment, by or with the consent (in England and Wales) of the Attorney-General or by the Director of Public Prosecutions, or summarily. If tried on indictment, the offender may be sentenced to a fine of £1,000 or 10 years' penal servitude, or to both fine and imprisonment, if summarily, to a fine of £250 or to imprisonment, with or without hard labour, for twelve months, or to both. If, however, the offence is one relating to the keeping of records, or the issuing or dispensing of prescriptions, was committed through inadvertence, and was not connected with any other offence or intended offence, the maximum penalty is a fine of £50.

32 Further, the Home Secretary has power, after the conviction of any doctor or dentist, to withdraw from him his authorization, the effect of this would be to deprive him entirely of the right to be in possession of or to supply the drugs.

V HOSPITALS, ETC

33 Hospitals, Asylums, Poor Law Institutions, or Sanatoria supported by a public authority or out of public funds or by a charity or voluntary subscriptions, have been exempted by Home Office Order from the operation of the Dangerous Drugs Regulations, subject to compliance with the conditions laid down in the Order. The terms of the Order (dated 15th August, 1921, and to be obtained from the Stationery Office) should be consulted.

34 The foregoing exemption does not apply to private hospitals, sanatoria, nursing homes, and similar establishments, where the full requirements of the Regulations must be strictly observed. No

person in such places may be in possession of or administer the drugs unless either he is a doctor or dentist or other person authorized by the Regulations, or unless he is administering the drug under the direct personal supervision of a doctor or dentist, or unless the drug has been supplied on a prescription (or dispensed by the doctor) for the use of a patient

VI INSPECTION

35 All registers and other records, required to be kept for the purposes of the Dangerous Drugs Act and Regulations thereunder, and any stocks of the drugs held, must at all times be available for inspection by any duly authorized inspector

36 As indicated in the opening paragraph of this memorandum, the Home Secretary has authorized Medical Officers of the Ministry of Health and of the Scottish Board of Health to act as Inspectors for this purpose in England and Wales and in Scotland respectively (This does not derogate from the general powers of inspection held by the Home Office Inspectors and the police which may be exercised, should special circumstances make it desirable)

37 Notice of a visit for the purposes of inspection will not necessarily be given, and medical practitioners who dispense should make such arrangements that the registers and other records can be produced, if required, for inspection in their absence

RECENT REGULATIONS

The Memorandum closes with an Appendix which shows the activity and care now being manifested by the Home Office in a matter of great professional importance Both the Acts—the Dangerous Drugs Act, 1920, and the Dangerous Drugs and Poisons Amendment Act, 1923—can be obtained for a few pence, as well as a series of Regulations applying to various drugs, and laying down general provisions for manufacture, possession, sale and distribution There are Regulations as to the genuineness of prescriptions and as to diversion of drugs in transit Additional Recommendations were made by a Departmental Committee on Morphine and Heroin Addiction in 1926, while the latest Regulations, also made last year, deal not only with prescriptions, possession and records, but set out the procedure of a disciplinary tribunal for cases of doctors supplying, administering or prescribing for themselves or others, otherwise than as required for medical treatment

It will be seen that the possession and prescription of the dangerous drugs offer many difficulties to the practitioner, and he will be wise to take counsel with one of the Defence Societies in any case of doubt, so as to ascertain the exact legal position.

PART IV
MEDICO-LEGAL SITUATIONS

CHAPTER XXII
MEDICAL EVIDENCE

Payment of Medical Witnesses Civil and Criminal Cases
—Fees in the High Court Expert and Non-Expert Evidence
—Some Familiar Advice—Evidence should be Clear, Definite
and Unbiased—Punctuality in Court—Disagreement of Ex-
perts—Dying Declarations

MEDICAL practitioners, whether they like it or not, are frequently required to give evidence in the law courts. If subpoenaed as witnesses in criminal cases they must attend, and when summoned to give evidence in civil cases they cannot safely absent themselves. Failure to attend in a criminal case might entail arrest and fine or imprisonment, and, in a civil case, damages might be recovered from the absentee for any loss arising from the lack of the evidence which he would have given if he had obeyed the subpoena. There is, too, the risk which he runs of being punished for contempt of court. Medical men and women have been known to refuse to attend on subpoena because they considered that the fee offered was too small, and judges have taken a very serious view of this attitude. The only way to avoid the risk of being compelled to give evidence is to keep clear of being in a position to be asked for it in a matter likely to be the subject of legal proceedings, and every doctor must here recollect that he is a citizen and that he may have a duty to perform.

THE MEDICAL WITNESSES' FEES

(1) *In Civil Cases*

The probability of being called as a witness is greatly increased if it is known what evidence would be given.

This should be borne in mind when a request is made for a report on a case which may lead to litigation. Before a report is given a guarantee should be required that an adequate fee will be paid, not only for the report, but also for giving evidence, or attending to give evidence, in the event of legal proceedings. After a report has been given the vantage ground for negotiating for a fee above the minimum amount legally prescribed has been lost, and the statutory fee may be a wholly unfair one, having regard to the time expended. In the event of a patient requiring the evidence of the medical adviser to establish a proper claim it would not be fair to raise any unreasonable difficulty, but, in the large number of cases where medical practitioners are not bound in duty to give evidence, they will be wise to take precaution to enable them to do as they choose, and to safeguard their position in the matter of proper remuneration. For instance, when a subpoena is served on a medical man he should ask for "conduct money," i.e. travelling allowance, to which he is entitled before going to court, he is not obliged to obey the subpoena until he has received it. If called on in court to give evidence he can ask to have his fee paid before being sworn, and the judge will then decide what is a proper fee in the circumstances. In most cases, even if not called, he would still be entitled to his fee. If he expects a higher fee than that ordinarily allowed on "taxation between party and party," he should arrange the matter clearly beforehand if he wishes to avoid disappointment afterwards. Fees thus arranged between witness and client are usually larger than those allowed on taxation.

(2) *In Criminal Cases*

The allowances to practising members of the medical profession for attending to give professional evidence in criminal prosecutions are as follows

For attending to give evidence in the town or place where the witness resides or practises,

If the witness attends to give evidence in one case only, not more than one and a half guineas per diem

If the witness gives evidence on the same day in two or more separate and distinct cases, not more than three guineas

For attending to give evidence elsewhere than in any town or place where the witness resides or practises, whether in one or more cases, not more than three guineas per diem "Town" means municipal borough or urban district, and "place" means within a radius of three miles from the court at which the witness attends to give evidence

There may be allowed to expert witnesses such allowances for attending to give expert evidence as the court may consider reasonable, including, where necessary, an allowance for qualifying to give evidence

No full day allowance will be paid unless the witness is necessarily detained away from his home or place of business or employment for at least four hours for the purpose of giving evidence. If the time is less than four hours the witness will receive not more than one-half of the allowances which he would have received if he had been detained for the full day

For attending court from a distance of over two miles there may be allowed to witnesses travelling by railway or other public conveyance, the fare actually paid

Railway fares, except for special reasons allowed by the court, will be third class, and if return tickets are available, only return rates are allowed. Where no railway or other public conveyance is available, and one or more witnesses necessarily travel by a hired vehicle, the sum actually paid for the hire of such vehicle, not exceeding 1s 6d a mile each way, is allowed, provided that, where two or more witnesses attend from the same place, the total allowance shall not exceed 1s 6d a mile each way unless the court is satisfied that it was reasonably necessary to hire more than one vehicle. To a witness travelling on foot, or by a private conveyance, where no railway or other public conveyance is available, a sum not to exceed 3d a mile each way is allowed

Fees in the High Court and Non-Expert Evidence

In the High Court the witness fees payable to a non-expert medical witness—that is, a witness of fact—are from one to three guineas, and in some cases the Taxing Master will allow five guineas. A witness attending the High Court is entitled to receive a sufficient amount of conduct money to take him to the court, and if there is any doubt in his mind as to the amount, or as to provision for his witness fees, he can raise the matter in court prior to his giving evidence.

Non-expert evidence from a medical man is a bare statement of the facts found by him, and if called as a non-expert witness he is not bound to give his opinion and deductions based on the facts which were present to him. It is difficult for a medical man to draw a hard-and-fast line, and he should, of course, in ordinary cases, where he is called as a witness of fact, be as helpful to the court as he can in the evidence he gives.

When a medical practitioner is called solely as an expert the amount of his fee is a matter of private arrangement between him and the persons calling him. He is entitled to a fee for qualifying (i.e. studying the subject so as to be competent to give expert opinions on questions arising) and for attendance, and he can refuse to give any evidence unless adequate provision has been made for his fees, or he can demand their payment before giving any evidence at all.

A point of some interest was raised in the course of a recent case, namely, whether a medical witness subpoenaed by one side had the right to restrict his evidence to facts observed by him, and to refuse to answer any questions intended to make him express an opinion on, for instance, the treatment given by another practitioner. The judge expressed his appreciation of the point, but gave no ruling. No doubt many a witness would be glad to refuse to give his opinions, and it would be convenient if it were recognized by the court that he is at liberty to do so. It is, however, doubtful whether a witness in this position could ever do more than this one did, i.e. protest, and leave the judge to

make any comment that the occasion may, in his lordship's opinion, demand. There is no precedent in law distinguishing a witness under subpoena from other witnesses. The question of whether a witness is one who can rightly be asked to express an opinion is always one for the judge. The witness can explain, if he feels he ought to do so, that he has not had such an opportunity to become acquainted with the facts as would qualify him to express an authoritative opinion on them. The judge would, no doubt, give weight to an objection so raised, but it is doubtful whether such a witness can have any right or privilege of refusing his evidence at his own option. Naturally, this point concerns only a witness who has attended unwillingly in obedience to a subpoena, and only to his evidence in chief. In cross-examination he would be liable to be asked for opinions if it were believed that his replies would be favourable to the side putting the questions.

SOME FAMILIAR ADVICE

There are general matters in connexion with the giving of all medical evidence to which attention has to be paid. The advice which follows will be familiar to most, and yet it is disregarded in many instances with results which may recoil on the medical witness.

The Importance of Being Understood

A medical witness should carefully avoid conveying to judge and jury the impression that he thinks they know but little of medical matters, but at the same time he should not reckon on their having any sound knowledge on medical subjects. They may not be as ignorant as the coroner's jury which gave a verdict that a man had died from a stone in the kidney swallowed by him when lying in a state of intoxication on a gravel path, but it is best to guard against possibilities of profound ignorance or curiously absurd notions. Even if a medical witness is able to avoid technical terms, and to give his evidence clearly and accurately in

ordinary language, there is still grave danger of serious misconception on the part of people whose medical knowledge is chiefly derived from quack advertisements, or from other sources not more trustworthy. Where it is possible, a medical witness should provide himself with specimens, models, or pictures, which will make clear many points which no words would ever make intelligible. The essential details of a fracture will be much better understood, for instance, if the medical witness can explain them with the help of articulated bones, and preferably ones showing a fracture similar to that under discussion.

Observations written down at the time may be referred to in giving evidence, but the original record or notes will be necessary for use in a court.

Answering—Yes or No

The rule that answers to questions should be direct and definite applies to medical evidence, but the difficulty of adhering to that rule is often very great for medical witnesses. Questions are often put—sometimes perhaps intentionally—direct answers to which, without qualification, might convey a very wrong impression. Nevertheless, there is no worse witness than one who answers questions hesitatingly and indefinitely, and then delivers a short lecture with a view to explaining his meaning. This kind of evidence gives excellent opportunities for cross-examination, and often ends in serious discomfiture of the witness with consequent damage to the case which his evidence should have supported. There are many questions which a witness cannot rightly answer by a simple Yes or No. If a witness is asked whether the habit of stating as facts things which are obviously untrue indicates the existence of insane delusions, he ought certainly not to answer simply Yes or No. The answer should be that it may or may not, and the witness can then wait for further questions and continue to answer them as directly and simply as possible. If instead of this he attempts to set out the methods by which distinction can be made between habitual lying and the

truthful expression of unfounded imaginations he will run great risk of failure, involving him in ridicule and discrediting him as a witness

Medical Evidence should be without Bias

A medical witness is usually called to give evidence on behalf of one side in a law case and not both, and he is often a witness for one of his own patients. This should not cause him to feel or show any desire to favour the side for which he is a witness at the expense of the other side. He should give his unbiased evidence fully and satisfactorily on behalf of those who, more or less, may depend on it for the establishment of their case, but he has a duty towards the other side of honesty and fair dealing. Consideration of the interests of those for whom he is giving evidence should, of itself, prevent his showing any signs of bias while giving evidence, and a medical witness should especially be on his guard in this respect when being cross-examined. The knowledge that cross-examination is intended to detract from the force of evidence given, and perhaps to discredit the witness himself, often leads that witness—sometimes unconsciously—to assume a hostile demeanour which serves only to assist the cross-examiner in his task. While, of course, guarding against snares, which are not likely to be laid for him except in the cross-examination, the witness should answer the cross-examiner with the same readiness and courtesy as when giving his answers to those conducting the case for the side on which he is giving evidence.

Punctuality in Court

Although attendance at a court of law is to the large majority of practitioners a business which cuts, in a very tiresome manner, into the day's work, the medical witness should be especially careful to arrive in good time. Coroners, magistrates and judges are apt to be ruthless in their comments on a witness who keeps the court waiting. If for some cause the witness is prevented from attending he

should communicate immediately with the officers of the court, giving full reasons, a word of tactful apology also would not be misplaced. It must occasionally happen, however, though very rarely, that a practitioner has to choose between keeping the court waiting and leaving a dying person unattended, and that there is neither time nor means of informing the proper authorities. In an emergency of this kind there can never be any question that the medical man's duty is to save life, if he really has cause to believe that life would be endangered if he did not attend to the patient. He will then have to trust to the courtesy and humanity of the court before which he was summoned, and should go there to make his excuse with the least possible delay. It need hardly be said, however, that the patient's need for immediate medical aid must be incontestable, and a witness bound over to appear before, say, an assize court should take every possible precaution against having to make a choice of this kind.

Disagreement of Expert Witnesses

It is a common reproach to medical as well as other expert evidence that it can be obtained in support of almost any proposition or theory which it is desired to establish, and it happens too often that expert witnesses of good standing confidently express diametrically opposite opinions on a subject which is undergoing legal investigation. The result of this may be the complete cancelling out of the expert evidence, leaving the matter quite undecided, or the question—which expert is right, and which wrong—may be answered by persons not at all competent to decide where doctors disagree. It is not much to be wondered at that experts support the point of view of those who call them as witnesses, because it is usual, before obtaining an expert witness to give evidence in a case, to ascertain what his opinion will be on the more material points. If his views are not favourable to the case of those proposing to call him as a witness, he is not asked to give evidence, and search is made for an expert whose evidence is likely to be helpful.

Consequently, if any suitable expert can be found who is prepared to give evidence such as is desired he is likely to be summoned as a witness. Without such previous selection there would be less conflict of opinion.

There can be no doubt that the medical evidence in many cases would be more consistent and more satisfactory if the medical witnesses conferred together before giving evidence, and not infrequently, in cases depending chiefly on the medical evidence, such conference would lead to a settlement without the trouble and expense of a trial. In a case, for instance, in which it was contended on the one side, and denied on the other, that serious consequences were due to injury of a nerve in the course of an operation, a consultation of the medical witnesses, with further investigation of the case, led to their arriving at the same conclusion, and obviated the necessity for further legal proceedings in the matter. When there is a real desire or willingness that a dispute should be decided justly, i.e. on its actual merits, there seems to be no sound objection to a conference of proposed medical witnesses beforehand, whether such witnesses will be called upon to give expert evidence or merely to give evidence of fact as to the condition of a person determined by medical examination.

DYING DECLARATIONS

When a patient is dying but is of sufficiently clear mind to give an account of the facts leading to his illness, it may become the duty of the medical man to take a dying declaration, and this may later become a matter for legal intervention. In cases of death by poison an opportunity may occur for declarations to be made, and in many accident and suicidal cases they may be of importance in removing suspicion from a third person in investigation before a coroner. A coroner is not bound by the strict laws of evidence which exist in criminal courts. The essential point of these declarations is that the individual must realize that he is about to die and has no hope of recovery. They should be made in the presence of a magistrate if

time permits, but if necessary must be taken down by the medical practitioner, by whom the following points should be observed

- (1) Secure a reliable witness
- (2) Make certain that the individual is convinced that he is about to die, a statement by him to that effect should be made in the declaration
- (3) Write the exact words of the patient
- (4) Ask only those questions which are deemed essential to clear up any ambiguous or doubtful points, and ask as few as possible
- (5) Record questions and answers
- (6) Read the declaration to the patient and get him to sign it or put a mark
- (7) Sign it and obtain the signature of the witness
- (8) If unconsciousness supervenes record as much as can be obtained, sign it and obtain the signature of the witness

Should the patient recover, these declarations are invalid, as the individual is then able to give evidence himself and be cross-examined. Dying declarations are based on a legal assumption that a person in sight of death speaks the truth, and also that he is in a fit mental condition to make his statements valid. If the practitioner has been able to secure expert opinion previously on the latter point it will much strengthen the chances of the dying declaration being admitted as evidence.

CHAPTER XXIII .

DOCTOR AND CORONER

Information to the Coroner—The Coroner's Officer—Medical Man as Informer—Post-Mortem Examinations—Medical Evidence at Inquests Fees of Medical Witnesses—Anæsthetic Deaths—Still-births and Infanticide—Scottish Procedure

THE duty of a coroner is to hold inquests on (1) cases of death under certain circumstances, (2) treasure trove, and (3) in the City of London on fires. We are only concerned here with the medical aspects of the coroner's duties.

The object of an inquest is to ascertain if death is due to criminal, avoidable or natural causes, further, to enable the guilty to be brought to justice, and to prevent and to limit accidents. Cases of death occurring in certain institutions are made by statute the subject of a coroner's inquest, this is done mainly to satisfy the public and the immediate relatives, so that any criticism directed towards those who were responsible for the custody of the deceased during life may be properly inquired into. Deaths from accidents in mines or factories fall into the same category, where the factory inspector must be informed by the coroner. Inquests of this type are just as much in the interest of the medical profession as in that of the public.

INFORMATION TO THE CORONER

The circumstances in which an inquest is to be held in cases of death are stated thus in Section 3 (1) of the Coroners Act, 1887. "Where a coroner is informed that the dead body of a person is lying within his jurisdiction, and that there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or has died a sudden death of which the cause is unknown, or that such person has died in prison or in such place or under such circumstances as to require an inquest in pursuance of any

Act," the coroner is to proceed to summon a jury and hold an inquest, whether the cause of death arose within his jurisdiction or not. It follows that a coroner does not take action until he receives information. Such information may come from any one of six sources: (1) his officer, (2) the police, (3) a registrar of births, deaths and marriages, (4) friends or relatives of the deceased, (5) medical practitioners (in attendance during life or after death), (6) private individuals. The duty of informing a coroner of a death, where it may be deemed desirable to hold an inquest, is not thrown on any person or persons by statute, except in the following cases:

- 1 A manager of an asylum in cases of insane persons under his charge

- 2 Cases of judicial hanging by the sheriff (who must inform the coroner prior to the execution)

- 3 Deaths in prison

- 4 Deaths which come within the scope of the Infant Life Protection Acts

Registrars of births, deaths and marriages are instructed by the Registrar-General to report to the coroner all deaths

- 1 Occasioned directly or indirectly by violence

- 2 Occurring in suspicious circumstances

- 3 The cause of which is stated to be unknown

- 4 Which are stated to have been sudden, and respecting which no certificate issued by a medical man is produced

- 5 Of infants in houses registered under the Infant Life Protection Acts

The coroner, having decided to hold an inquest, must do so within reasonable time of the death, although there is no statutory time limit laid down, and it is worthy of note that in one case the inquest was not held until 19 years after the death. Inquests have been threatened, or even held, upon bones, as to which it has been evident that they belonged to more or less remote antiquity, but to hold inquests in such cases is obviously unnecessary. In exhumation cases a considerable time may elapse between death and the inquest. It is the duty of a coroner to hold an inquest on any portion

of a body that may be found Under the 1926 Act he may act where a body is destroyed by fire or otherwise or is lying in some place where it is irrecoverable, if, on his report to the Home Office, the Home Secretary directs an inquest The 1926 Act also contains new provisions for holding one inquest where several deaths arise from one accident, for removing a body from one coroner's jurisdiction to another's, and for dispensing with an inquest where a medical report satisfies the coroner that an inquest is unnecessary

MEDICAL MAN AS INFORMER

When information has reached a coroner, he causes his officer to make inquiries, and as a result of the latter's investigations he decides whether or not an inquest is to be held By the Registration of Births and Deaths Act, 1874 (Section 20, Subsection 2), it is ordered that, "In case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign and give to some person required by this Act to give information concerning the death, a certificate stating to the best of his knowledge and belief the cause of death" The subsection giving particulars as to how the certificate is to be dealt with has been modified by Section 6 of the 1926 Act, the purport of which is given in dealing with death certificates in Chapter XV, p 140 *et seq*

There is a need for specific statutory directions to the medical man as to what he is to do where he cannot conscientiously give a certificate as to the precise cause of death, whether he believes it to be a natural death or not In practice he will generally inform the coroner if he finds that no one else is obliged to do so, particularly where he knows or has reason to think that death is not due to natural causes, or he will give a certificate so worded that the registrar will refuse to act upon it, and will inform the coroner It may not be necessary for the medical man to inform the coroner himself, in fact, neither under the 1926 Act nor any other Act is there any legal obligation for him

to inform the coroner. In practice, however, he can gain nothing by following the letter of the law, for the coroner is bound to receive information from other sources eventually, and the net result of this strictly legal proceeding on the part of the medical man will be a general delay of the proceedings and a general inconvenience to all concerned. The medical man, on the other hand, is warned to be certain of his facts before he gives information to a coroner, for should the reasons for his action be unsubstantiated by fact, he may find himself in a false position at a later period. The situation where poisoning is suspected is dealt with elsewhere in detail.

Accepting the principle that it is a duty of the medical man to inform the coroner in cases which are likely to be the subject of a coroner's inquest, the next point is what type of case should be notified. Many cases leave the medical man in no doubt as to his procedure, but there are a considerable number of cases in which one coroner would decide to hold an inquest whereas another would consider it unnecessary, for coroners interpret their duties very differently. Medical men are in a difficulty here, as by reporting certain cases in which a coroner does not hold an inquest they may incur hostility from relatives, and, on the other hand, by reporting too few their action may be criticized by the coroner. To overcome this difficulty, the prudent medical man will soon learn the idiosyncrasies of the coroner of his district and act accordingly. He may, however, find it a simple course in difficult cases and one which is quite in order—namely, to give a death certificate and at the same time inform the coroner that he has certified, and also of the salient facts of the case.

The following rules may assist him

- 1 Report if there is a history of an accident, no matter how remote

- 2 Report to the coroner (if he does not consider that he can conscientiously give a certificate assigning a natural cause for death) any facts which cause him to abstain from doing so or which point to the case being one for an inquest

under the section of the Coroners Act quoted above. He will remember that the coroner is to act where he has "reasonable cause to suspect" and that a coroner has jurisdiction to hold an inquest, and is justified in doing so, "if he honestly believes information which has been given him to be true, which, if true, would make it his duty to hold such an inquest".¹

3 Take no action in cases of suspicion only, unless the details on which the suspicion is based are capable of being substantiated in the witness-box.

4 Report those cases where it is known that if the medical man does not report someone else will.

CORONER'S INQUIRY

As soon as the information is lodged the coroner's officer is directed to make inquiries. Such inquiries are almost certain to include the practitioner involved. The practitioner should be at all times willing to help this officer in every way, but at the same time he must remember that the statement he makes to the officer, although of no legal import, is used by the coroner as the basis of his examination of the practitioner in the witness-box. He must, therefore, be guarded in what he says. Further, as this examination by the coroner's officer is not a legal proceeding, the doctor may refuse to answer any questions, especially those involving the confidential relations of doctor and patient, and those which may in any way reflect on his professional capabilities or conduct. But bearing this in mind, the practitioner is urged to be open in his dealing with this officer, as a refusal to give information, although quite within the rights of the practitioner, may place him in a false position at the subsequent inquest. Regarding the confidential relations of doctor and patient, the practitioner should decline to give any information to the coroner's officer. He should wait until questions involving this relationship are put to him in the witness-box and then only answer if his professional protest has been over-ruled.

¹ *Rex v. Stephenson*, 13 Q B D., 331

POST-MORTEM EXAMINATIONS

The coroner, having decided to hold an inquest, issues a warrant and summons various witnesses to attend. In the case of the medical man he may receive also an order to make a post-mortem examination. The performance of a post-mortem examination is generally delegated to the medical practitioner associated with the case, but there has been a growing tendency amongst some coroners to employ skilled pathologists for this purpose. This latter practice was recognized by Section 22 of the Coroners (Amendment) Act, 1926, which authorizes a coroner—apart from directing a medical witness to make a post-mortem examination—to request any legally qualified practitioner either to make such examination or to make a “special examination by way of analysis, test or otherwise, of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other special examination with a view to ascertaining how the deceased came by his death.” The doctor may be asked to make both an ordinary and a special examination, and the coroner may ask anyone “whom he considers to possess special qualifications for conducting a special examination as aforesaid” to conduct the latter. Anyone who is requested to make an examination under this 1926 provision may be called as a witness, and may be asked how in his opinion the deceased came by his death.

The practitioner associated with the case should be present at an inquest.

The holding of a post-mortem examination rests entirely with the coroner, who is naturally guided by the statements taken by his officer from the medical man and others. Here again there is a need for caution lest the coroner is led to think that the medical man is so satisfied as to the cause of death that no post-mortem examination would be necessary. It cannot too often be emphasized that if a case has features which make it a proper subject of a coroner's inquest, it is almost always advisable to hold a post-mortem examination.

Over and over again the interests of justice have been defeated or jeopardized by the failure of a coroner to order an examination. However, in justice to the coroner, it is fair to say that often the complete failure of a local authority to provide suitable facilities for this purpose has influenced him in his omission. The Public Health Acts in the majority of cases only give power to the local authority to provide mortuary and post-mortem accommodation, but do not make it compulsory. In certain instances there is no doubt that avoidance of post-mortem examinations and of toxicological analyses is dictated on the grounds of economy.

Medical men should beware of making a post-mortem examination unless they receive written authority from the coroner to do so. The body is under the absolute jurisdiction of the coroner, and even if he should give verbal consent such as "I do not order a post-mortem examination, but you may make one yourself if you like," on no account should the medical man act, for, should any future question arise, the doctor will be unable to shelter under the coroner, who has only power to act in the prescribed form. In such a case the doctor, of course, gets no fee for the examination. In important cases a skilled pathologist is sometimes called to make a second examination, which can only be legally done through a request made to the coroner by the jury. When a post-mortem examination is made, in every case without exception all organs, including the brain, must be examined by the medical man personally, and the work should not be delegated to the attendant. Those present at the examination, other than the attendant, should be persons authorized to be there by the coroner in writing.

During the examination, if the medical man as the result of his investigations has any suspicion that the deceased has died from the effects of poison, or is unable to exclude poison, it is his duty to place the whole (not portions) of the more important organs into perfectly clean stoppered jars which he himself has cleansed just prior to use, preferably each organ in a separate jar. He should on no account add any preservative. By this means the liver, kidneys, stomach and

contents, bladder and contents, and intestines in ordinary cases, and other organs in special cases, should be preserved. The jars should be made of glass entirely, for instance, a jar involving the use of india-rubber bands is unsafe, for a portion may be detached and become intermingled with the viscera, with the result that the analyst would possibly find antimony to be present, as manufactured india-rubber often contains this metal. This has actually happened in one case. The jars should be tied down effectively and sealed with a seal. Each jar should be labelled with the name of the deceased, date of examination, nature of contents, and signed by the person performing the examination. These jars should be handed to the coroner's officer and a receipt obtained for them. The coroner should be then informed that in medical opinion an analysis should be made. Too much care cannot be exercised over these details, which are so often neglected. Points of this kind are sometimes challenged by the defence, if a criminal charge supervene.

In cases where it is possible that the professional conduct of a medical man may be questioned by anyone, the coroner wisely directs another medical man to make the post-mortem. In such cases the medical man concerned may elect to be present himself or be represented at the examination by a colleague, to which the coroner usually gives consent although he is not in any way bound to do so. Similarly, an accused person or one who may be possibly the subject of subsequent proceedings, may also be represented by a doctor at the examination. The medical man should make careful notes, at the time of or directly after the examination, of all his findings. Where a witness on oath before the coroner has ascribed death to negligence or improper treatment by a medical practitioner or other person, "such medical practitioner or other person shall not be allowed to perform or assist at the post-mortem examination"¹. After May 1, 1927, however, the medical practitioner or other person in such a case has "the right,

¹ Coroners Act, 1887, Sec 21, Subsec 2

if he so desires, to be represented at any such post-mortem examination " ¹

This recent amendment of the law removes a possible source of injustice and prejudice where a practitioner is attacked. At a recent trial of a doctor a point was made for the defence that he had not been given an opportunity to be present at the post-mortem examination. In future a doctor will have this "right" as a matter of statutory privilege.

MEDICAL EVIDENCE AT INQUEST. POSITION OF MEDICAL WITNESSES

The coroner is not bound in any way to follow the rules of evidence which are strictly observed in other courts. He may take or refuse any evidence or testimony that he pleases. It is customary in all courts for the witnesses to remain outside the court until they are called to give evidence, after which they are allowed to remain in the court. The medical man, however, whose testimony is often taken last, is permitted to be present during the whole of the proceedings, as is the custom in other courts. His position is one of an expert witness and his presence in court is considered desirable so that he may hear the evidence given that it may assist him in arriving at his opinion as to the cause of death. Nevertheless, the coroner, as also the magistrate or presiding judge in other courts, may direct the doctor to remain outside the court until required.

Having been sworn, the medical man should give his evidence briefly and clearly, avoiding the use of technical terms wherever possible, and if such are necessary he should explain the same in simple phraseology. Above all, he should never be tempted to take up the position of lecturer and give the coroner and jury a discourse or a verbose account of what in his opinion were the circumstances of the death. Such advice appears to be superfluous, but evidence, if it may be called so, of this type is still too often given in these courts. The medical man must remember

¹ Coroners (Amendment) Act, 1926, Sec. 22, Subsec. 4

that the coroner's court is also a court of record, and that everything pertinent to the case is taken down in writing by the coroner or his clerk, and that he is subsequently called upon to sign this written statement. This document comes into the hands of the presiding authority of other courts, civil or criminal, and anything the doctor has said at the coroner's court in an unguarded moment may be thrown at him subsequently, with the result that he may be made to look foolish. When he has completed his evidence the coroner will read the transcript over to him and he will sign the statement. If he is in any way in doubt about what is written, he should make corrections at the time and read for himself carefully what is written, as once he has signed no correction may be made. He will then be bound over in a certain sum to attend at some other court in due course, if the case is to go further.

These remarks apply to every inquest, no matter how straightforward the case appears to be, and it must be remembered that there is always the possibility of any case being reopened in civil or criminal courts.

The fees of medical witnesses are now governed by Section 23 of the Coroners (Amendment) Act, 1926, and are at the following slightly increased rates

(a) For attending to give evidence at any inquest whereat no post-mortem examination has been made by the practitioner, one and a half guineas for each day on which he is required to attend, and

(b) for making a post-mortem examination of the body of the deceased and reporting the result thereof to the coroner without attending to give evidence at an inquest, two guineas, and

(c) for making a post-mortem examination of the body of the deceased (including the making of a report, if any, of the result thereof to the coroner) and for attending to give evidence at an inquest on the body, three guineas for the first day and one and a half guineas for each subsequent day on which the practitioner is required to attend.

If a medical practitioner makes a post-mortem examina-

tion without the previous direction or request of the coroner, these fees do not apply.

No provision is made for mileage or for adjourned sittings, at all of which the medical man is bound to attend, unless specially released by the coroner. There has always been some doubt whether resident medical officers of institutions, whose duties are to attend on the inmates of institutions such as lunatic asylums, hospitals, infirmaries, etc., are entitled to receive fees. So far as hospitals supported by voluntary contributions are concerned, the medical man is not entitled, the test usually adopted being whether the institution is supported by voluntary subscription or not. It has always been customary for medical officers of those not supported by voluntary subscription to be paid, but recently in some cases payment has been refused. The wording of the Act is obscure, and a test action to settle the point would be an advantage. If it can be upheld that medical officers of infirmaries can be refused their fees, it seems likely that all institutions in which sick persons are attended may be interpreted as coming under the scope of Section 22 of the Coroners Act, 1887. The matter is under dispute.

“ ANÆSTHETIC DEATHS ”

From the purely legal aspect it would seem clearly the duty of the coroner to hold inquests in this class of case. Exactly what is meant by the term “ anæsthetic death,” or “ death from anæsthesia,” is very difficult of definition. The anæsthetic is usually deemed to be finished as soon as the patient is “ round from the anæsthetic.” In most cases as soon as this stage is reached the patient is deemed, so far as the coroner is concerned, not to have died from the effects of the anæsthetic. It is obvious that in many cases where operations are followed by death inquests are unnecessary. The anæsthetist is quite aware that the patient may not survive the operation owing to the gravity of the condition. On the other hand, where an apparently healthy person undergoing a minor operation, or even a major operation which is not an emergency, dies under the anæsthetic,

it is eminently desirable for an inquest to be held. No medical man has anything to fear if his procedure was appropriate to the circumstances. The surgeon has been held at law to be responsible for everything which takes place in the operating theatre, and his testimony at the inquest is as important as that of those who in the eye of the law are his assistants.

STILL-BIRTHS AND INFANTICIDE

It is the duty of a coroner to hold an inquest on all newly born children where there are any suspicious circumstances relative to the death, and in certain cases under the Infant Life Protection Acts. There is, however, in this case a difficulty. A still-born child is not a person within the meaning of the Coroners Acts, and in many cases live birth can only be proved by a post-mortem examination. A coroner, however, who has reason for thinking that a child may have been born alive, can decide to hold an inquest, and having so decided can order a post-mortem examination. Still-births are defined by the Births and Deaths Registration Act, 1926 (see page 140), if the examination establishes still-birth, the registration provisions of that Act govern the further procedure.

SCOTTISH PROCEDURE

In Scotland there is no coroner, but the Procurator-Fiscal to a certain extent discharges similar duties. There is no public inquest, and the responsibilities and duties of the practitioner in Scotland are accordingly different in detail, but the advice connected with the giving of evidence is equally valid as a guide to professional attitude.

CHAPTER XXIV

LIBEL AND SLANDER

Defamatory Words — Libel and Slander — Malice, Privilege — Publication — Justification — Practitioner as Plaintiff — Practitioner as Defendant

EVERY medical practitioner ought to have a sound elementary knowledge of the law of libel and slander, for not only is he, by the nature of his profession, much exposed to libel and slander and very liable to serious damage from them, but he also runs serious risk, in the course of his professional duties, of himself libelling or slandering others, or of giving opportunities for accusations and claims for damages against him on the ground of alleged libel or slander. Before discussing the subject in reference to medical practice, a few elementary principles with which every practitioner ought to be familiar are set out

ELEMENTARY PRINCIPLES

Defamatory Words — Words which produce, in any given case, appreciable injury to the reputation of another are called defamatory, and defamatory words, if false, are actionable. False defamatory words, if written and published constitute a libel, if spoken, a slander. False words which by their nature evidently must damage the reputation are actionable without proof that any particular damage has followed otherwise it must be proved that some appreciable injury has in fact followed from the words spoken or written. Such evidence of "special damage" is not required when the words complained of were spoken of the plaintiff in the way of profession or trade or as holding an office of public trust, for it is assumed that disparaging words will in these circumstances cause injury even if specific instances of damage are not in evidence. In order to judge whether certain words are defamatory

or not it must be considered whether the nature of the words is such that it must be presumed that they would seriously injure the reputation of the person referred to as being disparaging or tending to bring into ridicule and contempt, when written, or, when spoken, as charging with the commission of a crime, with having a contagious disorder, with unchastity or adultery in the case of a woman, or as disparaging the person in his or her trade or profession. When it cannot be presumed that the words must cause appreciable injury it is necessary to prove that they have in fact produced injury to the patient's reputation. The presumption that words are defamatory arises much more readily in cases of libel than in cases of slander, since for several reasons words are more likely to cause injury when written than when merely spoken.

Malice—It is not necessary to prove that there was any wrong intention or motive in the use of defamatory words unless the words are privileged by reason of the occasion on which they were employed. Words, if false and defamatory, are actionable (when not privileged) even though published with an honest belief in their truth or accidentally or inadvertently. Absence of malice may, however, be pleaded in mitigation of damages. When the judge has ruled that the occasion was privileged in an action for defamation, the plaintiff has to prove malice. The question whether there was malice or not is for the jury, unless the judge rules that there is no evidence of malice to go to the jury. Malice in law is any indirect motive other than a sense of duty, the term does not imply only feeling against the plaintiff.

If malice is proved, the privilege attaching to the occasion, unless it be absolute, is lost. The fact that the defendant at the time of the publication of the defamatory words knew that they were false is clear evidence of malice, but even if the defendant honestly believed in the truth of what he said or wrote, and was acting under a sense of duty on a privileged occasion, still the words used and the manner and mode of their publication may afford evidence of malice.

Where the language used is much too violent for the occasion and circumstances to which it is applied, or utterly beyond and disproportionate to the facts, or where improper motives are unnecessarily imputed, there is evidence of malice to go to the jury.

Privileged Occasions—An occasion is privileged when the circumstances in which defamatory words have been written, or spoken, were such as to make it right that the writer or speaker should state what he honestly believes of the character of another, and should speak his mind fully and freely about him. Privileged occasions are of two kinds—those absolutely privileged, and those in which the privilege is qualified. Privilege is absolute in the case of words spoken by a judge on the bench, by a witness in the witness-box, and of words spoken in Parliament, and even if the words were spoken falsely, knowingly and with express malice they are not actionable. Where the interests of the public do not demand that the speaker should be freed from all responsibility, the privilege is qualified, and not absolute, and damages can be recovered in spite of privilege if it can be proved that the words were not used in good faith, but that the privileged occasion was made use of for the purpose of wilfully and knowingly defaming another. It is for the judge alone to decide whether or not a communication is, or is not, privileged by the occasion.

If the occasion is absolutely privileged judgment will at once be given for the defendant. If the judge decides that the occasion is one of qualified privilege only, and the plaintiff puts forward any evidence of malice sufficient to go to the jury, it is then a question for the jury whether the defendant was actuated by malicious motives in writing or speaking the defamatory words, and if the jury find that he was so actuated the protection of privilege is lost. A Medical Officer of Health reported unfavourably, at a meeting of the committee of his Town Council, on the work of a woman sanitary inspector and health visitor. The lady sued him for slander, and the defendant

pleaded privilege, but the judge held that there was sufficient evidence of malice for the case to be left to the jury, who awarded £25 damages. The Court of Appeal, however, reversed the judgment, holding that even though the defendant had frequently found fault personally with the plaintiff about her work, this did not constitute evidence of malice. One of their lordships pointed out that if the verdict were allowed to stand, a subordinate, who had been censured for defective work and later reported to superior authority in a communication which would otherwise be held privileged, would be able to rely upon the previous fault-finding as evidence of malice.

Publication —Publication is the communication of the defamatory words to some person or persons other than the person defamed. In civil proceedings communication of the words to the person defamed only is not publication. It cannot damage reputation. But when the words are such as obviously would provoke to a breach of the peace, criminal proceedings can be successfully taken when they have been communicated only to the person defamed, provided the words are written and not merely spoken. Criminal proceedings cannot be taken for slander.

Justification —It is a complete defence to any action for libel or slander if the truth of the defamatory words, on which the action is founded, is proved. In a criminal trial for libel this defence is not sufficient. The defendant must, however, prove that the words used were true in substance and in fact, and not merely that they were partly true. The onus of proving that the defamatory words were true rests on the defendant, and, failing such proof, they are assumed to be false. If the jury find that the words were true in substance and in fact they must find for the defendant, even though the words were used maliciously, if they find that the words were false they must find for the plaintiff, even though the defendant in their opinion honestly and reasonably believed that the words were true when he uttered them.

MEDICAL PRACTITIONER AS PLAINTIFF

To have and to maintain good reputation is a matter of very serious concern to medical practitioners, and they ought to give thoughtful and careful attention to the best means of protecting it against those who wantonly or wickedly seek to detract from it. Doctors are a frequent subject of gossip, but they should remember that it is not always defamatory, and that they may derive substantial benefit from it when it was intended to damage them. Ordinary foolish gossip should be altogether ignored, even though it be irritating and unfair, since, by dealing with it seriously as a slander, wide publicity may be given to it, and people may even be led to infer that it is founded on some substantial basis when it is mere irresponsible chatter.

Spiteful persons frequently write letters to medical practitioners accusing them of incompetence, malpraxis, negligence, or unprofessional conduct, they do this when annoyed by being pressed for payment of fees due for medical attendance, by refusal of untrue certificates in support of unjustified claims, by reprimands for recklessly giving unnecessary trouble, or by the expression of opinions with which they disagree or which are distasteful to them. A medical practitioner, on receipt of such a letter, sometimes answers angrily, demanding withdrawal and apology, with threats of legal proceedings. As there has been no publication of the libel, the writer can safely, and often does, reply reiterating his accusations and adding to them. When the practitioner proceeds to carry out his threats he learns to his disgust that he has no grounds for action, and that he has simply given the writer the gratification of knowing that his words have caused the annoyance they were intended to cause. Such letters should either be treated with silent contempt, or the writer should be told that his accusations are unfounded and that any publication of them to others will be appropriately dealt with. When letters of the kind are written by relatives of deceased patients, distressed by their loss, and unreasonably blaming

the doctor for his lack of success in his treatment, they should be answered firmly but sympathetically, and the unreasonableness of the accusations should be explained in a kindly spirit. In this way honest but foolish fancies can often be quite satisfactorily dispelled.

Medical practitioners should, if possible, avoid bringing actions for libel or slander, for, as has been suggested above, a wide publicity may be given to false charges which would not otherwise have reached more than very few, and in those quarters would have received little credence. It is very unwise to bring such actions when there is risk of failure owing to technical difficulties, apart from the truth or falsehood of the defamatory statements. People will often overlook the real reasons for the failure of an action, and regard it as a justification of the libel or slander complained of. The occasions on which doctors are libelled or slandered are very frequently more or less privileged, and proof of legal malice presents many pitfalls. Practitioners who are medical officers to public bodies, or panel doctors, are very liable to false charges made to the authorities whose duty it is to investigate such charges, and in these cases there is seldom enough clear evidence of malice to deprive the utterer of the protection of privilege. Members of boards of guardians, and of local councils, often make slanderous statements about medical officers, which are reported in newspapers. The slanderers, and the newspapers giving a correct report of their remarks, can plead privilege, but a newspaper which publishes the defamatory statements must, if requested, publish a denial of the defamatory statements, or it will render itself responsible for them. Such public contradiction is often the only remedy open to the practitioner who has been unjustly accused.

When a really grave libel on a medical practitioner is openly published, it should be promptly dealt with, and, failing an unreserved withdrawal and apology with publicity equal to that of the libel, legal proceedings should be taken, and full public vindication established. Unfortunately,

the originators of intolerable libels or slanders are, more often than not, impecunious, and careless what damages may be awarded against them, because the plaintiff cannot get from them what they do not possess. In such cases it may nevertheless be necessary to take legal proceedings so as to obtain an injunction restraining the defendant from continuing to publish the libels or slanders, and a disregard of the injunction can then be punished by imprisonment. Occasionally a medical practitioner receives a letter which constitutes a criminal libel although not published to others than himself—for instance, one accusing him falsely of criminally inducing abortion or committing a criminal assault. The warning, already given, of the necessity of securing the presence of a third person when administering anæsthetics to a female holds good, whatever the medical service to be rendered. Females should never be examined save in the presence of a witness. In such cases the practitioner should not shrink from prosecuting, bearing in mind that an unfavourable construction might be put upon his inaction if subsequently he should be prosecuted for the alleged offence.

MEDICAL PRACTITIONER AS DEFENDANT

A statement that a person is suffering from disease is often defamatory, and, as the most talented practitioner is liable to error in diagnosis, it may be false. The result of a statement by a doctor that a patient is suffering from tuberculosis or cancer may lead to his being dismissed from his employment if made to a third person, and the doctor may be liable for the damage resulting to the patient. Medical certificates should therefore be given to the patient himself and not to an employer, or friendly society, without the express authority of the patient. To talk about the ailments of patients to others is, of course, wrong and dangerous, and should be strictly avoided. Even though the protection of privilege may be available in the case of medical certificates or reports to employers or friendly societies, or the like, there is still a certain amount of risk

which it is discreet to avoid. If the truth of the statements made can be proved no damages can be recovered, but legal proof that a person is suffering from a particular disease is often extremely difficult, even when the diagnosis is in fact quite accurate. When there is a statutory duty to report that a patient is suffering from an infectious or other disease, it is sufficient to prove that proper care was taken in arriving at a diagnosis and that it was honestly stated according to the best of the practitioner's knowledge and belief. When a doctor violates the recognized rule of professional secrecy, and fails to prove the truth of damaging statements made by him about a patient, vindictive damages are not unlikely to be awarded against him.

Libel or slander of a fellow practitioner is suspected much more often than it occurs, but it is unfortunately not unknown. Alleged slander of doctors by doctors usually turns out on inquiry to have arisen from false reports by patients of what has been said to them, or sometimes from deliberately false statements by them. When one medical practitioner disagrees with the advice or treatment of another, he should weigh his words carefully, and not attribute ignorance, incompetence or malpraxis to a doctor who has honestly formed a different opinion, even if the latter has been wrong in his views or his treatment. It may be a duty to express definite disapproval of advice or treatment given, but, without clear proof, a doctor ought not to attribute negligence, want of skill, or wrong-doing to a patient's previous medical adviser, or make unfair or captious criticisms. To put the matter on the lowest grounds, to do so is dangerous.

CHAPTER XXV

ACTIONS FOR DAMAGES

Errors of Diagnosis—Precautions Against Accusations of Negligence—X-Ray and Bacteriological Examinations—Sharing the Responsibility—Errors of Treatment—Value of Consultation—Anæsthetics and Single-handed Operations—Delayed Complaints—Blackmail and Reasonable Settlement

ACTIONS for damages are rarely brought against medical practitioners in respect of alleged deliberate wrong-doing. Damages are claimed in the great majority of cases on the ground of negligence, or want of skill, or both. Want of skill is not often put forward as the main ground for claiming damages. To substantiate such a claim it must be proved that the skill exhibited was below that which any ordinary individual of the practitioner's standing in his profession would be reasonably expected to possess. A jury is not readily inclined to believe that a properly qualified doctor has not the average skill that all doctors are assumed to possess. If he has caused damage to his patient they are much more ready to believe that, while he had skill enough to avoid it, he did not take the trouble requisite for this purpose. The defence against a claim for damages consequently depends almost always on the evidence available in disproof of charges of negligence on the part of the doctor. Treatment, whether medical or surgical, is often unsuccessful. Patients die, or get worse instead of better, and the medical attendant may be blamed. In fact, with some people, it seems to afford them relief if they throw the blame for their misfortunes on someone else, and recent legislation, such as the Workmen's Compensation Act, appears to have created an impression that misfortunes or accidents should be alleviated by compensation at the expense of someone other than the sufferer in almost any circumstances.

ERRORS OF DIAGNOSIS

Precautions Against Accusations of Negligence

To obtain compensation from the medical attendant charges of negligence are readily trumped up, and they are often difficult to rebut. It is easy enough after the event to find fault with what has been done, and to contend that things which were left undone would have had far better results. Almost any line of treatment is open to criticism, and medical evidence is too often available in support of criticism more or less captious or unfair. Hence it becomes a matter of ordinary prudence for doctors to adopt precautions against accusations of negligence in their treatment of patients. Preventive precautions are, of course, best, but these will frequently fail, and it is therefore necessary to be prepared to defend a case successfully when attacked. It is a mistake to suppose that the most careful practitioner will be immune to attacks founded on allegations of negligence, while claims for alleged negligence, put forward without any just foundation by dishonest or foolish claimants, may be oftentimes very difficult to meet satisfactorily. Conscientious care in all cases is a matter of duty as well as of prudence, but it is also advisable to avoid all appearance of carelessness and to remember that the adoption of routine precautions, the making of detailed examinations, the employment of tests, and in general the outward indications of care, assume an importance quite beyond their due when a case goes into court. Especially important is the evidence of little details of the procedure adopted in arriving at a diagnosis when an error has been made, as will happen with the best of physicians or surgeons. A stupid mistake made in diagnosis, after a punctilious observance of all the appropriate rules for arriving at an accurate diagnosis, is much less likely to lead to legal disaster than the making of a mistake which could hardly or at all have been avoided, if any procedure recognized as advisable has been omitted, even though the practitioner has quite reasonably considered it unnecessary or useless.

X-Ray and Bacteriological Examinations

Consequently, in the case of injury of bones or joints, it will be a great advantage to the surgeon if an X ray examination has been made, for, if such examination has been omitted and the exact nature of a fracture or dislocation has not been detected, the omission will be described by plaintiff's counsel as gross neglect, and to it he will attribute any failure to attain a perfect result, even though it be a case in which permanent deformity was probable

Again, if a medical attendant has failed to detect a disease such as tuberculosis or diphtheria, it will be unhesitatingly assumed by plaintiff's counsel, and quite likely believed by the jury, that a bacteriological examination would have ensured an accurate diagnosis. It will be difficult, on the other hand, to prove that such an examination would not have been desirable or conclusive. A verdict of negligence, and an award of damages, is only too likely to result even though there be no reasonable grounds for the belief that a more precise knowledge of the conditions would have meant better treatment and a more satisfactory result

Sharing the Responsibility

It may seem, then, that it should be an absolute rule that such examinations should without exception be insisted on in the interests of the medical attendant quite apart from those of the patients. There are, however, in many cases, serious difficulties in the way of adopting this as a fixed rule. Patients and their relatives often object to the cost, and ask if the doctor thinks such examinations really necessary. Unfortunately, the fact that the doctor feels quite sure of his diagnosis, without special methods of examination, does not preclude the possibility of error, and the fact that any examination, at all likely to be made, will not alter the treatment, does not make the doctor's position safe if an error is subsequently detected. In remote country places the difficulty in the way of an X-ray examination is sometimes very serious, and it may be impossible to

arrange for it without prohibitive expense or the risk of ill consequences from the conveyance of the patient to a place where such examination is practicable. In these instances the responsibility should be laid as far as possible on the patient or the relatives in charge. The desirability of the examination should be clearly explained and any danger or expense that will be involved should also be pointed out. This should be done either in writing or in the presence of trustworthy witnesses, so that in the event of a claim for damages it can be incontestably proved that the patient was fully informed and accepted the position. Otherwise, the medical attendant may find his truthful assertions positively denied, and it may be supposed that he is only inventing excuses to justify his own negligence.

In some cases, when the doctor is convinced that unnecessary risk of a bad result will be run if the examination he recommends is not carried out, it may be advisable to refuse to continue in charge if his advice is not followed, but, of course, if the extreme step of withdrawing from a case is decided upon, proper care should be taken that the patient is not exposed to any risks thereby.

ERRORS OF TREATMENT

When every proper precaution has been taken against the risk of claims for damages founded on alleged wrong diagnosis, there still remain the risks that arise out of accusations of wrong treatment. The same condition or ailment is by no means always treated in the same way by different practitioners. Modes of treatment apparently quite different may be equally good, or opinion may be equally divided as to which is the best, or the mode of treatment approved by a distinct minority, or even by a single individual, may in fact be the best. Nevertheless, a judge and jury, knowing little or nothing of the matter, are apt to regard any departure from the recognized routine of treatment as being due to neglect to observe the ordinary rules of medical practice, and if a number of medical witnesses all admit that the treatment was not that

which they would themselves have adopted, the procedure may be condemned, even though quite suitable and quite carefully and deliberately adopted

Safeguard of Consultation

When a case presents special difficulties, or appears likely to have an unfavourable result, it is a great safeguard to call another doctor into consultation, and preferably one of high standing in the profession, or a specialist in cases of the kind. Here again the question of expense may have to be considered, and if it is objected to, the medical attendant will be well advised to provide himself with clear evidence that he had advised the calling in of a consultant, and that the responsibility for this not being done rests with the patient or the responsible relatives. Where medical assistance is desirable it should be asked for. When an operation is undertaken single-handed, and some mishap occurs which might conceivably have been avoided if another doctor had been present, the operator may be regarded as guilty of negligence in not insisting on medical assistance before undertaking the operation.

The Giving of Anæsthetics Single-handed Operations

It is seldom right to attempt to operate and anæsthetize at the same time. In midwifery cases it is not uncommon for a doctor to administer an anæsthetic and to instruct a nurse to continue the administration while he uses the forceps or performs some obstetric operation, and it is sometimes not easy or perhaps practicable to do otherwise, but if any mishap occurs the doctor will run the risk of being mulcted in damages unless he can prove that there would have been greater danger in waiting until medical assistance had been procured. When there is no need for haste, and the operation can be safely and properly deferred till a qualified anæsthetist can be obtained, it is not advisable to undertake the dual responsibility.

Again, it is seldom wise to perform even the more trivial operations without some responsible person being present

The experience of a patient fainting, or collapsing seriously under an operation, with imminent danger of sudden death when no one else is present, will make a doctor very reluctant to place himself in this position a second time (see Chap XI)

Delayed Complaints

It quite often happens that no complaint of any kind is made of the treatment of a patient until, perhaps after the lapse of a year or two, the patient is informed that steps will be taken to enforce payment of the fees which remain unpaid notwithstanding the frequent rendering of the account

It is desirable to have notes of cases dealt with, but in a busy practice it is exceptional for any record to be kept of anything beyond the visits and consultations and the medicines prescribed. Prescriptions should always be recorded, especially when any poisonous drug is prescribed, whether the doctor dispenses his own medicines or not. The value of full and accurate notes becomes evident when charges of negligence or wrong treatment are launched and payment is refused with a threat of action for damages. The doctor tries to recollect the case, and searches for any record of it, but if no proper notes have been made at the time the whole final result often amounts to a strong personal conviction that there is no foundation for the accusations—and to nothing more. In such circumstances it needs not a little courage to go into court, and the unscrupulous patient, quite appreciating the situation, knows that he has a very good chance of escaping payment although he has no grounds whatever for his complaints. If the doctor does not sue for his fees it may encourage his patient to venture on a speculative action for damages, or he may content himself with boasting that he accused the doctor of negligence and refused to pay him, and that the doctor was afraid to go into court.

BLACKMAIL AND REASONABLE SETTLEMENT

Exaggerated Importance of Many Claims for Damages

Threats of actions for damages against doctors are very common, and although they should be taken seriously

they ought not to be feared in the great majority of cases. The object of such threats is usually to avoid payment of fees, and sometimes it is a comparatively safe method of attempting to blackmail. A firm attitude is essential, and great care should be taken not to spoil a good case by hasty replies inspired by indignation or alarm. Naturally doctors have an exaggerated idea of the harm that may be done to their practices by actions for damages. In many cases, even when damages are awarded against them, the advertising influence of a case of public interest and the sympathy aroused among their friends and neighbours may more than counterbalance any ill-effects, if the evidence does not disclose clearly reprehensible conduct, or make the practitioners appear incompetent or contemptible. What renders actions for damages pecuniarily unsatisfactory is the fact that in most of the cases the plaintiff, when he loses his case, does not pay the defendant's costs, and consequently a successfully defended action involves heavy loss to the doctor, although, of course, such loss is lighter than if he had lost the case. The anticipation of such a result is not unlikely to weigh too heavily with a medical practitioner of scanty means if he has to defend himself, and it may lead him to yield to unjust demands to the encouragement of dishonest persons who seek to prey on medical men. In modern times it is to be feared that the law courts occasionally afford an effective means of dishonestly extorting money, because it is often cheaper to buy off a plaintiff than to defend an action successfully and pay the heavy costs of a barren victory.

Claims Suitable for Reasonable Settlement

There are claims for damages which should be honestly admitted, but not in such a way as to enable an unscrupulous person to use the admission for what is morally, though not legally, blackmailing. The human machine is not so perfect that it does not occasionally fail to avoid accidents which might be avoided, and although there may be no moral culpability, yet it seems only fair that the person

whose failure has caused the accident should bear the consequences, as far as is reasonable, rather than the person who is undoubtedly quite blameless. In such cases it is both honourable and prudent to settle a claim on reasonable terms, which should include on the part of the claimant an admission that there was nothing in the mishap for which liability is accepted which is discreditable to the doctor professionally. Care should also be taken that no loophole is left for subsequent claims on various pretexts which might be put forward after denial of legal liability had been rendered impracticable. When extortionate demands are persisted in they should be resisted if possible. In some cases, even when it is doubtful if there is any legal liability, but where the claim is a genuine one and the patient has in fact suffered damage, it may be advisable generously to give a "solatium" if it is accepted in a proper spirit and as a gratuitous donation, all legal claims being effectively withdrawn.

CHAPTER XXVI

POISONING AND SUSPECTED POISONING

Definition of Poison and Poisoning—Investigation of a Suspected Case—Problems after Recovery—Reservation of Specimens—Withholding the Certificate—Notification

ONE of the most harassing predicaments of medical practice is the occurrence of some incident which leads to the suspicion that a patient is the victim of foul play—whether by interference with the treatment prescribed or by the addition of poisonous substances to food or medicine. Most suspicions of this sort are totally incapable of proof and, indeed, turn out to be entirely unjustified. Nevertheless, all practitioners of long standing can recall occasional cases where subsequent events have not served to abolish their doubts. Homicidal poisoning is rare in this country when contrasted with some tropical countries, such as India, but it must be remembered that the criminals are not always brought to justice. The intimate relations of the medical man with the patient and the household place him in an unrivalled position for close observation of suspected cases, and he is sometimes able to avert tragedy.

Statistics of homicidal poisoning show both the reality of the danger to society and the difficult rôle which the doctor may have to play. From the figures the following points stand out: (1) The motive is generally of domestic, passionate, or greedy origin. (2) 30 per cent of homicidal poisoning occurs in towns and 70 per cent in country places. This need not be taken to imply that there are more criminals of this type in rural districts, but rather that the poisoner is more likely to be found out, since the family affairs are known in greater detail by the neighbours. In other words, the poisoner stands a greater chance of successfully evading detection in town than in the country. (3) Successful

poisoners often have more than one victim to their credit (4) Mostly the crime is premeditated, and often great craftiness is displayed (5) Far more males commit crime than females, but the percentage of females using poison is greater than males (6) The fact that often homicidal poisoning is only discovered after an exhumation has been made, the original burial order having been granted on the authority of a medical certificate of death, shows the particular responsibilities of the medical practitioner

DEFINITION OF POISON AND POISONING

Poisoning may occur as a result of one of the four following circumstances (1) Administration for homicidal purposes (2) Self-administration for suicidal purposes (3) Self-administration for a special purpose—e.g. abortion (4) Accidental administration But before discussing these possibilities in detail it is pertinent to inquire what, from the forensic standpoint, is a poison

It is the *intention* to murder or harm which constitutes the crime, substances not usually regarded as poisons may be poisons from the legal point of view if they are administered with evil intention The sections of the Acts relating to poisoning determine the nature of the offence according to whether murder, grievous bodily harm, or injury or annoyance was intended The law makes use of a variety of expressions, such as poison, noxious thing, destructive thing, stupefying or overpowering drug, matter, or thing, in order to make the statutes as comprehensive as possible For example, 24 & 25 Vict. ch. 100, sec. 11, reads "Who-soever shall administer or cause to be administered or taken by any person any poison or other destructive thing with intent to commit murder shall be guilty of felony" In the section dealing with the administration of chloroform, etc., for stupefying, whereby a felony can be committed, the words used are "chloroform, laudanum or other stupefying or overpowering drug", in the statute dealing with abortion the words are "poison or noxious thing" Various judicial decisions, although clearing the legal position, have

thrown great responsibility on the medical witness. It has been laid down that (1) there must not only be an administration of a noxious drug with guilty intent, but it must have been administered in sufficient quantity as to be noxious, (2) if a person administers with intent (in the particular case in which the ruling was made "to procure the miscarriage") something which as administered is noxious, he administers a "noxious thing". A distinction is to be drawn between a thing that is only noxious when given in excess and one which is recognized as a poison and known to be noxious and pernicious in its effect. The law does not make any distinction regarding the mode of administration. Administration hypodermically, by mouth, per rectum, or elsehow, of a poison with intent to murder or injure is a punishable felony. The only question that will be raised is whether the substance dealt with is noxious. Similarly also the admixtures of cultures of micro-organisms or their toxins are equally poisons and have the same significance. The medical witness will have to decide whether a substance was noxious and whether it was given in excess, and take into consideration the age, health, tolerance of the victim, and the possibility of repeated administration of small doses.

The phrase "grievous bodily harm" has been defined as the infliction of an injury which seriously interferes with health or comfort or both, it need not be permanent or dangerous.

HOW TO INVESTIGATE A SUSPECTED CASE

The method of approaching an investigation, when, from information received from a second person or from personal observation, suspicions are aroused that foul play may be occurring, requires careful thinking out. Suspicions, once aroused, soon assume formidable dimensions unless each incident is critically examined and a natural explanation sought, and rarely are they subsequently justified. During the two years subsequent to the mention of poisoned chocolates in the case of *R v Armstrong* numbers, probably

running into hundreds, of samples of chocolates were submitted to analysts in this country alone, in only two or three cases was poison found, and in those cases the tampering with the sweets was of the crudest nature

When poisoning is suspected the doctor should attempt to take apparently motiveless steps to circumvent operations by alteration of diet or the time of day at which food is given, in order to make things difficult for the suspected person. If medicines are suspected as being tampered with they should be changed, in such a way that a poison may demonstrate itself by taste or colour change—a dye-stuff may be added so that the addition of an alkaline or acid substance would be seen. A nurse may be engaged or a previous nurse changed, and given strict orders to prepare food, but she should not be given a hint of what is going on. Visitation of the patient by a suspected person may be forbidden for ordinary medical reasons or only allowed in the presence of the nurse. The aim of the doctor should be not only to protect his patient, but also, if possible, to detect the poisoner, and thus prevent future attempts. If serious symptoms develop removal to a nursing home or hospital should be insisted on, so that the patient is out of reach of danger. Careful notes of everything that happens must be made at the time and kept for reference. Specimens of excreta likely to contain poison should be saved, especially those passed within twenty-four hours of the time when the poison was suspected of being given. The doctor should himself carry them to his house, and should keep them in a clean closed vessel, sealed and labelled.

A brother practitioner should be called in consultation and suspicions communicated to him, in this way an independent witness is made available if required, and, moreover, the benefit of advice for future conduct of the case is obtained. Further than this it is not feasible to go unless suspicions are supported by fact. Without provable facts it is impossible to set the machinery of the law in action. A communication to the police would at once start an elaborate investigation, questioning, and even perhaps

detention of individuals, possibly a search of the house and probably publicity would ensue, all of which, unless the suspicions were correct, would at least inflict great hardship on innocent individuals. It might lead to a possible action for damages against the medical attendant and the ruin of his practice should the suspicions be not subsequently confirmed.

When information is given to the doctor by a member of the household suggesting that a third person is attempting to poison the patient, the doctor should advise the informer to communicate with the police if sufficient proof is available. Probably the proof will be insufficient and no steps will be taken. The doctor should then invite the individual to cooperate with him in endeavouring to bring the allegation to a satisfactory termination, but he must at the same time be on his guard against false evidence actuated from interested motives, and against an attempt of a guilty person to throw the blame elsewhere. The doctor must feel his way with the utmost caution, but he cannot afford to neglect the information. In such a case, if the patient is confined to his bed through illness, the doctor may with advantage urge removal to a nursing home or hospital.

In some cases the doctor may first hear of the suggestion of poisoning through the supposed victim (A), who may come to him armed with the various articles of consumption believed to be poisoned. Such cases may be divided into the following headings: (a) suspected poisoning of (A) by (B), a named individual but with motive unknown, (b) suspected poisoning of (A) by a lunatic or border-line case or uncertifiable case—e.g. the husband is often suspected by the unbalanced wife and vice versa, (c) suspected poisoning of (A), a border-line case, by a relative, (d) suspected poisoning of (A) by a person interested—for example, financially—or by a companion likely to benefit. Regarding these conditions motive, except in the first example, will have been found by the informant who believes that the poisoner has a grievance—e.g. love affairs, pecuniary reasons and so forth. Generally speaking,

these charges are without foundation, and incipient insanity of either party dependent on changes associated with involuntional states must be borne in mind. The practitioner's duty here is as follows. He will at once instruct the victim to collect material or excreta for analysis, or will arrange for the analysis to be made on the material already produced, at the expense of the victim, and advise the victim to wait for the result before action is taken by him or her. (He will be prudent to get the needful fees for analysis in advance.) If the victim is in a highly nervous state from worry, the practitioner should suggest going a visit to friends until the result is known. When the result is known the victim may be satisfied that he or she is wrong or, what is more likely, will not be satisfied, alleging that the analysis failed to find some subtle poison. If the doctor cannot alleviate suspicion by persuasion he can but advise going to the police, but on no account should he take this step himself. If he knows of some reliable relative who will intervene, he should urge the patient to inform the relative so that a consultation may be held as to what steps are to be taken. Inquiry by the police will, of course, come to naught in that large majority of cases where no crime exists. The police will interview the doctor, who should give a full and unbiased opinion of the state of affairs as he sees them. If the doctor can satisfy himself that the aggrieved person is in an abnormal mental state, he may be well advised to inform him, her, or those against whom the allegations have been made with a view to preventing possible assaults or retaliation, and possibly with a view to having the individual certified or provided with a nurse companion.

PROBLEMS AFTER RECOVERY

The patient's recovery does not necessarily end the problem for the family doctor. The doctor is often puzzled, when a case recovers, as to what is his duty regarding the lodging of information. Attempted suicide and the taking of poison for the purpose of abortion, for example, are felonies and are punishable by law. Technically, the doctor

is an accessory after the fact if he fails to disclose what knowledge he is in possession of. But in how many cases is his knowledge founded on established fact? Further, what information he may have discovered will be hearsay or the statement of a person unsupported by witnesses, so that when he has to testify he may be met with a denial. One person's word, contradicted and unsupported, will not be accepted in a court.

Further—and this is the consideration that might have been put first—the doctor is bound by his professional obligations to his patient, to keep sacred what he has learned in a professional capacity, indeed the faith of the patient in these obligations may have resulted in a confession which would not otherwise have been made. The point was dealt with at some length by the late Mr Justice Hawkins, who fully realized the position of the doctor and made a pronouncement which is worth quoting in full.

“It was also said by the medical witnesses (referring to evidence given in the case) that, if in the course of professional practice they came across a case which indicated either that a crime had been committed or was about to be committed, under these circumstances they were bound to divulge it. To whom? To the Public Prosecutor! If a poor, wretched woman committed an offence for the purpose of getting rid of that with which she was pregnant, and of saving her character, her reputation, and, it might be, her very means of livelihood, and if a doctor was called in to assist her—not in procuring abortion, for that in itself was a crime—but called in for the purpose of attending her, and giving her medical advice—that she might be cured so as to go forth to her business—he doubted very, very, very much whether he would be justified in going forth and saying to the Public Prosecutor, ‘I have been attending a poor young woman who has been trying to procure abortion with the assistance of her sister. She is now pretty well, and is getting better, and in the course of a few days she will be out again, but I think I ought to put you on to the woman.’ To his mind, a thing like that would be monstrous cruelty. He did not know what the jury’s view would be, he spoke only of his own.”

The judge is quoted only in connexion with cases of unsuccessful suicide, and of abortion, the doctor appearing in a professional capacity.

There is also the case where a person has purchased the poison and handed it to the poisoned person, who voluntarily takes it—e g for procuring abortion. In absence of definite evidence of the fact the doctor can do nothing, but in the presence of positive evidence it may be his duty here to give information so that the accomplice may be apprehended, when the taker of the poison would probably become a Crown witness. In the case of a death pact between two persons by poison where one recovers, the doctor should inform authority, and the recovered person will probably be charged with felony.

To return to suspected homicide, the question of informing a convalescent patient of the nature of the illness will depend on the analyst's report. If positive, the patient must be informed of the nature of his illness, and if the evidence has been sufficiently strong to detain anyone, this fact must also be communicated to him. If, however, no action is likely to be taken against any suspected person, the suspicions had better not be communicated to the patient, further investigation being left to his initiative.

THE RESERVATION OF SPECIMENS THE COST OF ANALYSIS

In cases of suspected homicidal poisoning, whether the poison is known or not, the medical attendant should reserve specimens of excreta and partly consumed food for analysis. A difficulty arises regarding the cost of the examination. It is hardly likely that the suspected homicide will agree to pay for the analysis, thus providing condemnatory evidence, and, indeed, it may be impolitic to acquaint him or her that poisoning is suspected at that stage of the investigation. Any mention of the fact to the patient will also be equally undesirable, unless the patient also suspects poison. The doctor is, therefore, faced with two alternatives (1) To bear the cost himself, which is obviously unfair, as his chance of the recovery of the cost is remote, whatever the issue. (2) To inform the police and request them to take the necessary steps for an analysis. This, as has been already pointed out, will necessitate inquiries at a stage

when the medical attendant desires to avoid them. There is, however, a third course which may assist the medical attendant in his difficulty. He may make application to the Under Secretary of State, Home Office, for assistance, giving a full account of the matter and the reasons for his suspicions. The Under Secretary of State may then cause an analysis to be made at the expense of public funds, if he thinks that the facts warrant it. The authorities at the Home Office, fully realizing the delicacy of the doctor's position, can delay active inquiry into the case until the result of the analysis is known. Such an application should only be made in serious cases, but is a resort which may be of great assistance in an anxious situation. Should the Home Office consider that it is a case for their intervention they will inform the doctor of the necessary procedure.

It is obvious that every article of food or medicine which may be suspected of being tampered with should be reserved and kept under lock and key by the medical attendant. All excreta, urine, fæces and vomit should be similarly treated, and especially those leaving the body within twenty-four hours of the time when the suspected poison was believed to have been taken. There may be room here for much ingenuity, as such extensive activity on the part of the doctor may defeat its own object by putting the poisoner on his guard, while causing anxiety to the patient. The doctor may have to be content with reserving one or two articles, positive findings in excreta are of greater value, as they prove the fact that the individual did actually imbibe poison. Generally speaking, the urine will be the most valuable specimen to reserve and the easiest to procure, and in order to obtain sufficient the doctor can ask for night and morning specimens and have them passed in his presence. The material or materials reserved should be placed in clean bottles, personally rinsed out by the doctor just before filling. They should be securely corked and sealed by him and labelled with the patient's name, date of collection, the nature of the material, and the initials of the doctor. On no account whatsoever should

any preservative be added. It does not matter if the contents become foul during the time which elapses between the taking of the specimen and the analysis. The possible risk of a poison becoming decomposed is slight, but the addition of an antiseptic (in most cases a poison) may so complicate the examination that the analyst may be unable to give a definite report on the presence of poison. The doctor should content himself with keeping the bottles in a cool place, and, of course, in his own custody.

WITHHOLDING THE CERTIFICATE

If the medical attendant cannot give a certificate of death from some natural cause the coroner must be informed. If the patient is a stranger to him he should be specially on his guard, since a homicidal relative may send for a stranger rather than a medical man who knows the family well. Failing to obtain a certificate from the doctor who does not know the family, he may then apply to the family doctor, who knows the deceased's "constitution" and who may be tempted to give a certificate on the strength of that general knowledge.

In all cases of death from poisoning it is the duty of the medical attendant to withhold certification of the death and immediately to inform the coroner of the circumstances. This should be done as soon as possible, to enable the authorities to commence inquiries at the earliest possible date. Thus the event of accident or suicide will be cleared up without any suspicion, and at the same time the police will be best enabled to collect information to apprehend any guilty party in homicide cases. In cases where poison is only suspected the medical attendant must consider whether his suspicions are sufficiently certain and capable of proof to warrant his withholding the certificate. Further, he must consider whether anyone else is likely to inform the police if he does not, whether the police are likely to hear of the matter through any gossip, and whether any open accusation has been made in the household of the deceased in his (the doctor's) hearing. If scandal has occurred, it

is the medical attendant's duty to put the facts before the coroner and to abide by his decision

The doctor should, before leaving the house, take possession of any bottle, tumbler, food or material suspected of containing poison. Relatives even in suicide cases often attempt to destroy this evidence in the hope that any stigma resulting from the coroner's inquest may be avoided. The doctor may be pressed to give a certificate of death to avoid these inquiries, but he must be firm in refusal, else he may land himself in a very difficult position with the coroner, to say nothing of a possible charge of false certification of a legal document.

NOTIFICATION

In the case of patients suffering from chronic poisoning caused through the nature of their employment, it is the duty of the medical attendant to notify the Chief Inspector of Factories at the Home Office, giving the name and address of the patient and the nature of the disease from which the patient suffers. The Factory Inspector and Certifying Surgeon of the district in which the factory or workshop is situated should also be notified.

PART V

THE PUBLIC SERVICES

CHAPTER XXVII

POST-GRADUATE EDUCATION THE SPECIAL DIPLOMAS

Diplomas in Public Health, Tropical, Psychological and Ophthalmic Medicine, in Medical Radiology and Electrology, in Laryngology, Otology and in Tuberculous Diseases—The Significance of Post-Graduate Work

IN previous observations upon the medical curriculum it was pointed out that there is necessity to-day for post-graduate education

All whose official duties in various Services deprive them of regular chances of keeping abreast with medical progress now obtain study leave at regular intervals throughout much of their careers, and, in setting out the arguments for believing that the best opening for the young practitioner is entrance into partnership, stress was laid upon the fact that partnership allows for the provision of such leave

We have now to consider the medical career when it is led as the officer of some Public Service, fighting or civil, State or otherwise, and here post-graduate training of some definite sort is often demanded by the regulations guarding entrance into the service, while it is always the readiest passport to promotion. Post-graduate education is necessary for the obtaining of special diplomas, and the particular value of these is seen as the special directions of medical practice are dealt with. But the need of all for a continual keeping-in-touch with scientific and technical developments is the great lesson that is being taught by those developments, and throughout the changes that are taking place, as well as throughout those that are contemplated,

in public and private practice, the authorities and the doctors alike should be insistent to make all reforms go hand-in-hand with provision for post-graduate training

The young practitioner has been compared to a sailor setting out on a voyage over changing seas, who is for a time well served by his charts, but later meets with emergencies which necessitate their revision. He finds that he requires help in dealing with new currents, that new soundings have made old observations obsolete, and that fresh waters have been opened which were uncharted when he first put forth. But as medicine is ever progressive, the position of the beginner in practice is constantly repeated as he grows older in his work, and the need for a revision of knowledge is felt. While the establishment of centres for post-graduate education is to-day recognized as a necessity, we are as yet only at the dawn of the movement.

In London little more than a beginning has been made to supply post-graduate instruction. The vast size of the metropolis and the absence as yet of any one clinical centre present a most difficult problem. Several years ago the Athlone Committee recommended that a school attached to a hospital centrally constituted in London should be devoted solely to post-graduate medical education, a school of the University of London being suggested, but the obstacles to be overcome have as yet compelled inactivity. The Fellowship of Medicine has done its best to remedy the defaults in London for post-graduate education, and has placed at the disposal of medical graduates a fine assortment of sound teaching, but the great hospitals of the metropolis have a routine for their undergraduate students which assorts ill with post-graduate lectures and demonstrations, and the experience of those who have thought most on the subject calls for the institution of a special medical post-graduate centre.

This ideal remains for attainment, but the number of influential persons interested in the movement and the real need point to early developments

Many things are combined in the words "post-graduate education," for the needs are many. Some practitioners require a general recapitulation of the lessons they learned at their hospitals, others wish to take out a course of instruction along a special branch of practice, and yet a third class intend to obtain a diploma to enable them to practise along particular lines. But the acquisition of a diploma is the accompaniment of, not the reason for, post-graduate work.

THE SPECIAL DIPLOMAS

In the Students' Number of the *Lancet* there is published yearly an epitome of the instruction given at various universities and centres of medical education to medical men desirous of possessing the special diplomas. These can be obtained to-day in seven subjects, namely, in Public Health, in Tropical and in Psychological Medicine, in Ophthalmology, in Medical Radiology and Electrology, in Laryngology and Otology, and in the study of Tuberculous Disease.

A difference between the diploma in public health and that available in all the other subjects is that it can be registered, and the reason for this is that the General Medical Council has exercised its educational function by standardizing the course necessary to obtain the diploma. The discrimination between the position of those who hold the D P H and those who hold the other special diplomas is therefore logical, while there is no agreement as to the advisability of making the other diplomas registrable. Many of those who hold them point to the injustice of not being able to append the additional title to their names on the Register. The Register is published for the information of the public, and inconvenience, they consider, may be, and has been, caused by the fact that a practitioner's just claim to the possession of one of these titles will appear fictitious to anyone who consults the official roll, expecting to find confirmation. The position is well known to the General Medical Council, which body puts forward no objec-

tion to the registration of special diplomas, if accompanied with the necessary standardization of the examinations, but the various bodies who grant the diplomas are not, at any rate all of them are not, prepared to welcome the intervention of the Council. As long as this difference of opinions remains, all the special diplomas except the D P H will be unregistrable, and every practitioner possessing one of them must be prepared to produce his testamur if his claim is challenged—an admitted source of trouble

The Diploma in Public Health

The diploma in public health is regulated by resolutions of the General Medical Council which came into force in 1923, and which have extended the period of study and have postponed the granting of the diploma until at least two years from qualification. The diploma is granted by the Universities of Oxford, Cambridge, London, Durham, Manchester, Birmingham, Liverpool, Leeds and Bristol, by the University of Wales, by the Universities of Edinburgh, Aberdeen, Glasgow and St Andrews, by the Universities of Dublin and Belfast and the National University of Ireland. The diploma is also granted by the Royal Corporations of England, Scotland and Ireland. All application for information upon the various schedules, needful periods of attendance, and obligatory courses of lectures and practical instruction should be addressed to the deans of the various medical faculties or to the secretaries of the corporations, the course of studies has been standardized, making the various curricula analogous in the essential points

Diploma in Tropical Medicine

Although a diploma in tropical medicine has not been made registrable by statute, it is regarded as indispensable for appointments in the Colonial Medical Service and similar positions abroad. Systematic instruction for these diplomas is given at the Incorporated Liverpool School of Tropical Medicine founded in 1898, and at the London School of

Tropical Medicine, 5 Endsleigh Gardens, N W 1, which is a school of the University of London

At the University of London the M D degree may be taken in tropical medicine at an examination held twice annually, for which a thesis may be submitted

The University of Liverpool grants a D T M, open only to those who have been through a course of instruction at the school. The examination is held at the end of each full course, details of which can be obtained from the Dean of the Medical Faculty. A diploma in tropical hygiene, D T H, has recently been established at the University of Liverpool, and the two are taken together

At the University of Cambridge the examination is held in two parts, Part I in April and Part II in July. The diploma D T M & H is held in both subjects, and is only for graduates, but the qualifications may be either of British origin or from some source which is recognized by a proper authority in a country outside the British dominions

A diploma of D T M & H is awarded by the Conjoint Board R C P Lond, R C S Eng to qualified men who, before study and examination, must produce evidence of having attended courses in the pertinent subjects, as well as the clinical practice in those subjects, at a recognized centre for not less than five months. The conditions of study, however, may be modified in the case of candidates of special experience. Further information can be obtained from the Secretary of the Board, Examination Hall, Queen Square, W C 1

Diploma in Psychological Medicine

The Universities of Cambridge, London, Durham, Leeds, Manchester and Edinburgh, Trinity College, Dublin, and the Conjoint Board R C P Lond, R C S Eng grant diplomas in psychological medicine, D Psych M, under conditions that are fairly comparable in the standard of the tests and in the duration of the courses, the details on these points can be obtained from the various bodies

In London, courses of instruction for the diploma in

psychological medicine are given at the Maudsley Hospital, Denmark Hill, a school of the University of London, where appointments as clinical assistants are obtainable, the holding of which for varying periods satisfies the requirements of the different examining bodies in respect of practical study. The appointments and other facilities for clinical experience are open to qualified medical practitioners apart from the courses of instruction. Inquiries as to lectures should be addressed to the Director of the Pathological Laboratory, Maudsley Hospital, Denmark Hill, S E 5, and as to clinical facilities, to the Medical Superintendent at the same address.

House physicians are appointed at Bethlem Royal Hospital for a term of six months or more. Clinical assistants are appointed from time to time for periods of three months or longer. These are non-salaried and non-resident posts.

Courses of instruction are held in Edinburgh for the University diploma, which is open to approved registered practitioners as well as to graduates. The advantages of the instruction given at Morningside and elsewhere are well known.

In Ireland a post-graduate diploma is conferred on registered medical practitioners who, subsequent to registration, have held for at least twelve months a resident medical appointment in a recognized hospital for the treatment of mental diseases, or have held such an appointment for at least six months and have also attended daily for six months on the practice of an approved institution as aforesaid in which clinical instruction is given, they must also have attended certain courses of instruction and have passed a special examination.

Diploma in Ophthalmic Medicine

Special diplomas in ophthalmic medicine and surgery are issued by two examining bodies.

The diploma in ophthalmology (D O) is granted by the University of Oxford to registered medical practitioners after passing an examination, held annually in March, which is

open to candidates who have pursued at Oxford a course of study in ophthalmology over a period of at least two months and who have attended a twelve-months' recognized hospital course. Further information regarding these requirements may be obtained from the Dean of the School of Medicine.

The Conjoint Board R C P Lond, R C S Eng grants a diploma (D O M S) after an examination held in two parts, twice yearly, in January and July. Part I comprises anatomy and embryology of the visual apparatus, physiology of vision, and elementary optics. Part II comprises optical defects, ophthalmic medicine and surgery, and pathology with special reference to ophthalmology. The examination in each case is written, oral, and practical or clinical. Candidates may only enter for Part II on completion of a year of special study of ophthalmology after obtaining a registrable qualification.

Diploma in Medical Radiology and Electrolgy

This Diploma (D M R & E) is granted by the University of Cambridge. It is open only to those who hold a medical qualification, and includes a course of lectures and practical work in Physics (Part I) and in Radiology and Electrolgy (Part II). Attendances at the necessary course of lectures in both subjects, and, in addition, six months' clinical experience in an adequately equipped hospital recognized by the Committee, are essential. The whole course of study takes six months, though this is likely to be increased in the future, the lectures, practical work and hospital attendance running concurrently. Two courses of study are now recognized by the University of Cambridge. One course begins in London in October in preparation for the examination in the following April, the other course begins in Cambridge in January and the examination can be concluded in the following July. In the Cambridge course three months are spent in Cambridge over the lectures and practical work, and attending the practice of Addenbrooke's Hospital. The remaining three months can be completed at any

recognized hospital, but special arrangements are made for candidates to continue their studies in London

An independent six months' course is arranged by the British Institute of Radiology This course is held entirely in London, but is recognized by the University of Cambridge as qualifying for the examination, and begins early in October Further particulars as to the Cambridge course can be obtained from Dr F Shillington Scales, Medical Schools, Cambridge, and of the London courses from Dr Stanley Melville, at the Offices of the B I R, 32 Welbeck Street, London, W 1

Diploma in Laryngology and Otology

The Conjoint Board R C P Lond, R C S Eng grants the diploma (D L O) after an examination held in two parts, twice yearly, in June and December Part I comprises anatomy, embryology and physiology of the ear, nose, pharynx, larynx, trachea and bronchi, and oesophagus Part II comprises the medicine, surgery and pathology of the ear, nose, pharynx, larynx, trachea and bronchi, and oesophagus, and the recognition and use of special instruments and appliances The examination in each case is written, oral, and practical or clinical Candidates may only enter for Part II on completion of one year of special study of the diseases of the ear, nose, pharynx and larynx, after obtaining a registrable qualification

Diploma in Tuberculous Diseases

A diploma in tuberculous diseases is given by the University of Wales Graduates must be not less than twenty-five years of age, and either (Category A) have held, for a period of not less than five years, whole-time appointments for work in tuberculosis, or (Category B) have held a registrable qualification to practise for at least one year, and presented (a) a certificate of satisfactory pursuance of a course of consecutive post-graduate study of the clinical and epidemiological aspects of tuberculosis of six months' duration at a recognized university, medical school or hospital

where such a course is given, or, alternatively, a certificate of one year's post-graduate work as a whole-time member of the staff of a tuberculosis hospital, sanatorium or dispensary approved by the Ministry of Health, signed by the representative of the authorities for whom the work was performed or by the administrative medical officer concerned, (b) a certificate of satisfactory pursuance of a course of consecutive post-graduate practical study of the pathology and bacteriology of tuberculosis of three months' duration at a tuberculosis laboratory or a recognized general laboratory where such a course is given, (c) a certificate of three months' satisfactory attendance at a tuberculosis institute or dispensary. The examination is divided into two parts. Applications should be made to the Registrar of the University, University Registry, Cathays Park, Cardiff.

THE SIGNIFICANCE OF POST-GRADUATE WORK

The importance of post-graduate education is now widely recognized. Diplomas have been instituted in order that practitioners desiring to work along special lines of practice may have the means for standardizing that work. In general practice the value of study leave is admitted, and facilities—still much short of what is desirable—are provided at teaching centres by post-graduate organizations so that doctors can obtain general “refresher” courses or intensive instruction in a speciality. In the Public Services study leave is arranged for, or definite significance is given to the possession of special diplomas. In the Fighting Services specialist appointments obtained after post-graduate work are accompanied with increase of pay, while at certain stages in the officer's career qualifying examinations which can only be passed after post-graduate study precede promotion. In the Colonial Medical Service there is a welcome given to the candidates who hold the apposite special diplomas, while a course of post-graduate instruction is in some places compulsory. The Public Health Service demands two years of post-graduate work, and other civil medical appointments depend upon study after qualification.

CHAPTER XXVIII

PRACTICE IN THE FIGHTING SERVICES

Naval Medical Service A Short-Service System Pay and Retired Pay—Army Medical Service the Professional Career Pay and Retired Pay—Indian Medical Service Special Recruitment Pay and Retired Pay—Air Force Medical Service Temporary and Permanent Pay and Retired Pay

THE conduct of practice in the Naval Medical Service, the Army Medical Service, the Indian Medical Service and the Air Force Medical Service is duly ordered by regulations made for the establishment of these Services, for admission and for promotion within them, and for retirement from them and pensioning. So that the larger part of the previous chapters may have no application to the officers of these Services, if they remain in their original careers, but a good number of them retire upon gratuity to enter general or special practice, and it is probable that this course will become more frequent. The information in respect of conditions of work, rates of pay at home and abroad, and allowances is published regularly in the Students' Number of the *Lancet*, where tabular statements are given with respect to these matters. These detailed particulars which are so freely accessible have not been repeated, here it is sufficient to indicate what the income of the officer is at certain stages of his career, and what the pecuniary position will be upon retirement, to enable decision upon the future in respect of practice.

THE NAVAL MEDICAL SERVICE

The result of the recommendations of the Interdepartmental Committee on the medical branches of the Fighting Services, which took effect on July 1, 1926, caused many changes to be made in the conditions of service, and all of them are to the benefit of the Naval Medical Officers. There has been an increase in the establishment of surgeon-

captains, two of whom will be appointed to Haslar as professors respectively of medicine and surgery, the directorship of medical studies at the Royal Naval College, Greenwich, will in future be held by a surgeon-captain, and an officer of the same rank will be appointed at the Hospital at Malta. An increase has been made both in the allowances to medical officers doing specialist work and in the number of these appointments. There are now specialist posts in medicine, surgery, radiology and hygiene, all of which carry allowances. There is also a new scale instituted of extra pay for officers in charge of hospitals and sick quarters.

Similarly, the opportunities for keeping abreast with medical knowledge have been much increased. Officers below the rank of surgeon-captain will, whenever possible, be spared once in every four years to take a course of clinical medicine and surgery at Haslar, lasting not less than four months, after which, until they receive employment elsewhere, they will be appointed for duty at the Haslar, Chatham or Plymouth R N Hospitals. Every officer selected to hold a specialist appointment will be set free, if his services can be spared, for a course of six months' tuition in his special subject at a recognized teaching centre, and he will subsequently have a course of three months' instruction in the subject every four years while he is employed as a specialist. These general and special courses are not yet in full operation, but they mean a great reform.

Seniority on entry will be granted to those who have held, not less than one year before entry, a resident appointment as medical or surgical officer in a recognized civil hospital, and in certain circumstances a similar privilege will be granted to those who have spent six months as non-residents.

The rank of surgeon-leutenant-commander is granted six years after the date of entry, and special promotion is made in cases of conspicuous merit. Six years later promotion to surgeon-commander is obtained after a qualifying examination, and here again special promotions are made on the ground of professional merit as well as for distinguished service. It may be said that all special pro-

motions are limited in number, save of course, for gallantry in action, but general recognition of professional attainment should prove an incentive to progressive scientific work

Entry into the Service A Short-Service System

But the most striking part of the Naval Medical Service to-day is that the regulations for entry by examination into the permanent Service are in abeyance, a short-service scheme now providing alike for recruiting and for transfer to the permanent Service. The regulations for the entry of surgeon-lieutenants under this scheme provide that the candidates should be of good character and physique, duly registered medical men and not above thirty years of age. The conditions imply three years' engagement to serve when and where required under the general rules of the Service as regards discipline, with rank as, but after, surgeon-lieutenants in the permanent Service and to receive two calendar months' notice of being no longer required.

Pay and Emoluments

The pay of the Naval Medical Service is shown in the following table, and those intending to join the Service

STANDARD AND PRESENT RATES OF PAY

Rank	Standard rate		Rate from July 1, 1924	
	Year of 365 days	One day	Year of 365 days	One day
	£ s d	£ s d	£ s d	£ s d
Surg -Lieut on entry	438 0 0	1 4 0	413 13 4	1 2 8
After 3 years	529 5 0	1 9 0	498 16 8	1 7 4
Surg Lieut Comdr on promotion	638 15 0	1 15 0	602 5 0	1 13 0
After 3 years	675 5 0	1 17 0	638 15 0	1 15 0
Surg Comdr on promotion	821 5 0	2 5 0	775 12 6	2 2 6
After 3 years	894 5 0	2 9 0	845 11 8	2 6 4
" 6 "	967 5 0	2 13 0	915 10 10	2 10 2
" 9 "	1,040 5 0	2 17 0	982 9 2	2 13 10
Surg -Capt on promotion	1,186 5 0	3 5 0	1,122 7 6	3 1 6
After 3 years	1,277 10 0	3 10 0	1,207 10 10	3 6 2
" 6 "	1,368 15 0	3 15 0	1,292 14 2	3 10 10
" 9 "	1,460 0 0	4 0 0	1,380 18 4	3 15 8
Surg -Rear Admiral	1,916 5 0	5 5 0	1,809 15 10	4 19 2

must remember that the rates are subject to periodical revision in the light of the cost of living. A standard scale was introduced in 1919, 20 per cent of which is variable.

The rates of retired pay are as in the following table, but here again it must be remembered that 20 per cent of all the rates of retired pay is variable with the cost of living and the rates at present in course of payment are slightly lower than these figures show.

RETIRED PAY

Age on retirement	Retired pay	Period of service (years) counting towards retired pay	(A)		Age on retirement	Retired pay	Period of service (years) counting towards retired pay	(A)	
			Addition	Deduction				Addition	Deduction
	£ (p a)		£ (p a)	£ (p a)		£ (p a)		£ (p a)	£ (p a)
55	790	24	22	15	47	562	20	15	15
54	765	24	22	15	46	525	20	15	15
53	742	23	22	15	45	487	19	15	15
52	720	23	22	15	44	450	19	15	15
51	697	22	22	15	43	412	18	15	15
50	675	22	15	15	42	375	18	15	15
49	637	21	15	15	41	337	17	15	15
48	600	21	15	15	40	300	17	15	15

(p a) = per annum

(A) Addition for each full year's service in excess of that specified in column 3 or deduction for each full year wanting to complete that period of service—addition or deduction limited to five years in each case.

All these regulations have their similars in the Dental Branch of the Navy, where, however, no higher rank than surgeon-captain (D) is open.

ARMY MEDICAL SERVICE

The publication of a new Royal Warrant in 1926 has gone a long way towards removing grievances of the officers of the Royal Army Medical Corps, and competitive examinations which had been in abeyance for some time are now projected. The rates of pay and allowances are good, the opportunities for post-graduate study are generous, and

the work is varied and interesting as well as responsible. In days not so long gone by these things could not be said accurately. Although there is no recognition of temporary service, as has occurred in the Naval Medical Service, still the gratuities after certain periods enable any officer, should he so desire, to leave the service with a sum which will assist towards establishing him in civil life. Temporary commissions are now given for home stations.

After a total service of one year at home and generally of some five years abroad, the officer will find that, including leave, he has reached a seniority in the service where he has an opportunity of deciding whether he will remain, or prefer to accept the gratuity of £1,000 after seven years' service. If he elects to remain, he will between his eighth and twelfth year of service undergo a course of post-graduate study at the Royal Army Medical College and the London hospitals of five months' duration, followed by a course of study in subjects selected by himself, provided that he has shown special aptitude thereto. During this period of study he remains on full pay, and the fees for any course are paid by the State. When qualified in his special subject, the officer becomes entitled to specialist pay at 5s per day if holding a specialist appointment. After this post-graduate course the officer probably proceeds abroad again and promotion to major rapidly ensues, and from that time onward the officer receives regular successive increases of pay, and is eligible for additional and charge pay as well. The Directorates of Hygiene and Pathology and the appointment of two serving officers as consultants in medicine and surgery have been instituted and have proved a marked success, all these appointments being of the rank of colonel or major-general.

Under these conditions the possibilities for good workers are very great in the Royal Army Medical Corps. There is scope for original research in tropical disease, in preventive medicine, and in bacteriology, as well as in the large clinical field open to the specialist in medicine, surgery or gynaecology, in venereal disease, and in ophthalmology. Child

welfare is also undertaken systematically by officers of the Royal Army Medical Corps

At the same time instruction in administration is continuous, for all officers must be prepared to undertake command and to have a knowledge of Army administration, especially in war. Many appointments carrying administrative responsibility are open to those officers who display capacity for this duty

Pay and Emoluments

The pay and allowances are shown in the table on the opposite page

Retired pay consists of two parts (a) a service element based on the officer's total service, (b) a rank element for the rank from which the officer retires. An officer with less than twenty complete years' service will not be eligible for retired pay. The scale will be as follows, subject to the reduction of $5\frac{1}{2}$ per cent referred to below

(a) Service element—£15 a year for each completed year of service as a medical officer

(b) Rank element—

Rank from which retired	After completing 1 year's service in the rank	After completing each additional year's service	Maximum rank element
	£	£	£
Major		12	120
Lieutenant Colonel	150	30	240
Colonel	290	50	390
Major-General	440	50	540
Lieutenant General	590	50	690

The retired pay of an officer retiring with less than one complete year's service in the rank from which he retires will be assessed as though he had retired from the rank below

Maximum rates of retired pay (a) and (b) together

	£		£
Captain and Subaltern	300	Colonel	800
Major	450	Major General	1,000
Lieutenant Colonel	600	Lieutenant General	1,200

The above rates are those in the Pay Warrant. They have been reduced by $5\frac{1}{2}$ per cent as from July 1, 1924

PAY AND ALLOWANCES

[illegible]

Officers with seven and less than 20 years' service as medical officers may be permitted to retire with a gratuity in accordance with the following scale

After 7 years' service as a medical officer	£1,000
„ 3 „ „ in the rank of Major	£2,800
„ 6 „ „ „ „ „	£3,500

The Dental Service is well organized

INDIAN MEDICAL SERVICE

The entry of European medical candidates into the Indian Medical Service practically ceased with the last open competitive examination held in 1915, and it is no secret that the recruitment for the Service had for many years previous not been brisk, with the result that at the present time the Service is well officered in its higher ranks and notably deficient in the ranks of those who will be called to succeed them. Among the seniors and retired officers are many whose work in medicine and the allied sciences has become a household word, for a generation ago the conditions of service were such as to attract men of the greatest promise in the medical schools, who were rarely disappointed in a career which, without producing wealth, gave wide opportunity for the display of talent in research, and for administration unfettered by irksome restriction. We may suppose (and it is the view of many senior officers in the Service) that the period of depression is now passing and that the prospect is now brighter for those who are fitted in physique and disposition for a medical career in India.

But the new outlook involves frank acceptance of the Indian reform scheme, the essential of which is increasing participation of Indian-born subjects in the government of the country, although, so long as Europeans are employed in the various departments of the Indian Civil Service, nothing is more certain than that there will and must remain European doctors to attend them. Entrants should also be prepared to face the fact that more time will elapse before

they can hope to get into civil employ and that opportunities for private medical practice are not what they were. On the other hand, it is reasonably certain that the social effect of Indianization will not press hardly on the medical service for the reason that European doctors will be chiefly requisitioned in stations with considerable European communities. In these communities the equipment and organization of hospitals has been steadily improving, and men with professional ambition will find positions which will satisfy their aspirations. On the military side the station hospital system has rendered the position of medical officers more independent, making team-work possible and permitting of specialization in various departments of medicine and surgery. Lastly, those who join now will have unequalled prospect of advancement in a Service which has been so depleted for ten or fifteen years or more, and the new terms of service announced by the Secretary of State for India assure conditions of pay, pension and furlough much superior to those recently offered.

Special Recruitment

Special terms for permanent commissions may be offered to a small number of medical men of European descent free to sail for India promptly. Candidates, who must be well qualified and between 21 and 32 years of age, will be appointed on the nomination of a selection committee before whom they will appear in person. The special advantage offered is the option of retirement on a gratuity at the end of a short specified period of service—£1,000 after six years, £2,500 after twelve years—and if the option is not taken up the officer will continue in the Service on the ordinary pensionable footing. They will be eligible for the concessions granted in the new provisional regulations and for free passage if invalided home on sick leave during the first twelve years. Military employment only is guaranteed, but they will enjoy the benefits of any conditions regarding civil employment applicable to officers appointed later to the Service.

as a result of decisions taken on the Lee Commission report

The New Provisional Regulations

Competitive examination remains suspended for the present and admission to the Service is on written application to the India Office. As sound bodily health is a first essential candidates may undergo a preliminary examination by a Medical Board which meets weekly at the India Office.

Candidates must be under thirty-two years of age at the time of application and possess qualifications registrable in Great Britain. Up to the present time officers have been employed both in civil and military departments and have been interchangeable between the two. In view, however, of the recommendations of the Lee Commission only military employment can be guaranteed to officers entering at the present time, although they will be eligible for such civil employment as may become available as a result of the Lee Commission report. Executive medical officers in both civil and military employment may attend persons unconnected with Government service provided their duty admits of it. On the military side, however, the opportunities for private practice are not great. Service during the war as a medical or combatant officer, or in a position usually filled by an officer, counts towards promotion and pension so long as the rights of officers who have entered by competition are not interfered with.

Officers on appointment are, when possible, provided with passage to India by transport. When such accommodation is not available passage is provided by private steamer, or passage allowance granted if preferred. The wives and families of officers who are married prior to the date of the officers' embarkation on first appointment will also be given free passage to India. Officers are granted a certain number of return passages home at Government expense, and there are special allowances for officers whilst on study leave.

Rates of Pay

The monthly rates of pay for European officers in the Service are as tabulated below —

Rank and service in rank	Basic pay	Overseas pay		Year of total service
		If drawn in sterling	If drawn in rupees	
	Rs	£	Rs	
Lieut	500	—	150	First
		—	150	Second
		—	150	Thrd
Captain				
1 During first three years' service as Captain	650	—	150	Fourth
2 With more than three and less than six years' service as Captain		15	150	Fifth
		15	150	Sixth
	750	25	250	Seventh
		25	250	Eighth
		25	250	Ninth
3 With more than six years' service as Captain	850	25	250	Tenth
		25	250	Eleventh
		30	300	Twelfth
Major				
1 During first three years' service as Major	950	—	—	—
2 With more than three and less than six years' service as Major	1,100	—	—	—
3 With more than six years' service as Major	1,250	30	300	Thirteenth and over
Lieut Colonel				
1 Until completion of 23 years' total service	1,500	—	—	—
2 During twenty fourth and twenty fifth years' total service	1,600	—	—	—
3 After completion of 25 years' total service	1,700	—	—	—
4 When selected for increased pay	1,850	—	—	—

Until the completion of 23 years' total service basic pay is regulated according to rank and service in rank (column 1) which, owing to the system of accelerated promotion, may be in advance of the time-scale of promotion. Overseas pay is regulated solely with reference to length of total service (column 5). In addition to grades there are a number of appointments as colonels on Rs 2,200 to Rs 2,500, according to the appointment held, and as major-general on

Rs 2,750 The appointment of Director of Medical Services in India, carrying pay at Rs 3,200 per mensem, may also be held by an officer of the Indian Medical Service

Initial rates of pay are based on the assumption that the majority of newly appointed officers will be bachelors. An officer, when junior, is liable to more frequent changes of station than later on in his service, and he may therefore be put to considerable expense for transfers if he has a family. Officers who are married before joining may find difficulty in living within their pay during the first few years of their service. Officers in military employment, when in command or second-in-command of the larger station hospitals, receive special allowances. On the civil side there are public health, bacteriological, research and professorial appointments carrying special enhanced rates. Special rates of pay are attached to administrative appointments. Officers on appointment receive an outfit allowance of £50.

Pensions and Allowances

The rates of pensions are as shown in the table below.

There are additional pensions not subject to the above reduction ranging from £125 to £350 per annum for officers who have held high administrative appointments as colonels or major-generals.

Service	Rates per annum	Service	Rates per annum
After 17 years	£400	After 23 years	£620
“ 18 “	430	“ 24 “	660
“ 19 “	460	“ 25 “	700
“ 20 “	500	“ 26 “	750
“ 21 “	540	“ 27 “	800
“ 22 “	580		

Note—The above rates are subject to revision, upwards or downwards, to an extent not exceeding 20 per cent in all, on account of a rise or fall in the cost of living, as compared with the year 1919. A deduction of 4 per cent on this account has already been made. A further revision may take place on July 1, 1927, and every three years thereafter.

ROYAL AIR FORCE MEDICAL SERVICE

The Air Council attach great importance to attracting into the Service the best type of medical man, since on the capacity of the Medical Service depends in a peculiar degree the safety and efficiency of the Air Force. The duties of a medical officer in the Air Force include not only the prevention and treatment of those ordinary diseases to which the personnel of any fighting service are liable, but the special study of the mental and physical stresses imposed on the airman in diverse circumstances and climates—a branch of medicine providing considerable scope for research.

As promotion to the higher ranks of the Service is by selection from officers who are eligible by reason of length of service, and as a certain proportion of the higher ranks will be reserved for purely scientific as opposed to administrative appointments, there are excellent prospects for the young medical officer who exhibits ability and energy in scientific research, or develops a talent for administration. The work to be done has a high professional interest which, combined with good rates of pay and allowances, offers a career for medical men which should prove both attractive and interesting. The life is one which is certain to appeal to the man of wide outlook who desires opportunities for travel, sport and games, and can find interest and enjoyment in aviation. For he will gain that flying experience as a passenger which is necessary for the proper study of the medical problems of aviation and for first-hand knowledge of the conditions under which his comrades serve.

Permanent and Short Service

The establishment consists partly of permanent and partly of short-service officers. Medical officers may be allowed to count as service their time spent in resident appointments in civil hospitals under certain well-defined and generous conditions.

An officer will on first entry be granted a short-service commission for a period of three years on the active list (which may be extended to five years at the discretion of the Air Council if the officer so wishes on the recommendation of the Director of Medical Services) and of four years in the Reserve of Air Force Officers. Selections for permanent commissions will be made from officers holding short-service commissions, and those who are not selected will be transferred to the Reserve at the expiration of their period of service on the active list.

For those entrants who desire it the prospect of obtaining a permanent commission is approximately an even one, and experience has shown that the officers selected have included the great majority of those desirous of, and suitable for, retention in the Service. The short-service commission with its gratuity after three or five years attracts many entrants who desire to enlarge their experience before entering private practice.

Arrangements exist whereby, in the event of a short-service medical officer being approved for a permanent commission and there being no vacancy on the establishment, consideration may be given to his transfer to the Royal Army Medical Corps as a permanent officer. If transferred his service in the R A F would count towards increments of pay and retired pay in the R A M C.

Officers who have been selected for permanent commissions may be permitted to attend for a period not exceeding nine months a post-graduate course in general medicine and surgery, tropical and preventive medicine and other special subjects. Such permission may be granted at any time when the exigencies of the Service permit during the first sixteen years of service, and when attending these courses officers will receive full pay and allowances.

Entrance to the Service

New entrants will be commissioned as Flying Officers

(Medical) and be eligible for promotion to the rank of Flight Lieutenant (Medical) after two years. Officers selected for permanent commissions will normally be promoted to the rank of Squadron Leader after ten years' total service. Accelerated promotion may be granted in a limited number of cases to officers who show exceptional ability after the completion of eight years' service. Promotion within establishment to the rank of Wing Commander will be by selection at any period after sixteen years' total service, and that of Group Captain by selection at any period after twenty-two years' service.

There will be no competitive examination on entry, candidates must be under twenty-eight years of age, and qualified registered medical men, be British subjects, the sons of British subjects, and of pure European descent, and be nominated by the dean of a recognized medical school or teaching hospital, they will be interviewed personally by the Director of Medical Services, R A F, before acceptance. Each candidate will be required, before acceptance, to pass a medical examination and on appointment will undergo an initial course of eight weeks, during which he will be given instruction in the special medical aspects of aviation, the organization, administration and general and special duties to be performed.

Rates of Pay and Emoluments

The emoluments of medical officers of the Royal Air Force are given in outline below. As in the case of the pay in the Royal Army Medical Corps, the standard rates were drawn up on the basis of the high cost of living in 1919, and 20 per cent is subject to alteration as the cost of living rises or falls, the current rates representing a reduction of approximately $5\frac{1}{2}$ per cent on the standard rates. The next revision will take effect from July 1, 1927, and subsequent revisions will be made at intervals of three years.

ROYAL AIR FORCE MEDICAL SERVICE RATES OF PAY AND ALLOWANCES

Rank	Pay *		Per annum (current rate)		Cash allowances in lieu of quarters, rations, and servant, if not available in kind (per annum) †				Pay plus allowances per annum			
	Daily rates		Current									
	Standard											
	£	s	d	£	s	d	£	s	d	£	s	d
Flying Officer	1	4	0	1	2	8	413	13	4	158	3	4
Flight Lieutenant—	1	6	0	1	4	6	447	2	6	206	16	8
After 2 years as such	1	8	0	1	6	6	483	12	6	206	16	8
After 4 years as such	1	10	0	1	8	4	517	1	8	206	16	8
Squadron Leader—	1	14	0	1	12	2	587	0	10	206	16	8
After 2 years as such	1	18	0	1	15	10	653	19	2	206	16	8
After 4 years as such	2	0	0	1	17	10	690	9	2	206	16	8
After 6 years as such	2	4	0	2	1	6	757	7	6	206	16	8
After 8 years as such	2	8	0	2	5	4	827	6	8	206	16	8
After 10 years as such	2	10	0	2	7	4	863	16	8	206	16	8
Wing Commander—	2	15	0	2	12	0	949	0	0	206	16	8
After 2 years as such	2	17	0	2	13	10	982	9	2	206	16	8
After 4 years as such	3	3	0	2	19	6	1,085	17	6	206	16	8
Group Captain	3	10	0	3	6	2	1,207	10	10	282	17	6
Air Commodore	4	0	0	3	15	8	1,380	18	4	337	12	6
Air Vice Marshal	5	0	0	4	14	6	1,724	12	6	404	10	10

* Except for periods of service under Indian administration For such periods officers receive pay and allowances at rates and subject to conditions authorized from time to time by the Government of India

† These allowances are issued only when accommodation, fuel and light, rations and personal attendance are not available in kind Normally, provision in kind is available for junior officers "Married" rates of allowances are payable only to married officers who have reached the age of 30 A colonial allowance is granted to certain commands abroad The rates and general scheme of allowances are liable to revision as circumstances may require.

Retired Pay

The minimum period of service qualifying for retirement on retired pay is twenty years. Standard rates of retired pay are as follows

AIR OFFICERS

Air Vice Marshal	£790 to £1,010 per annum
Air Commodore	£650 „ £950 „

OFFICERS BELOW AIR RANK

Age on retirement	Standard yearly rate of retired pay	Years of service	Addition for each extra year of service *	Deduction for each deficient year of service *
	£		£	£
40	300	17	15	15
41	337	17	15	15
42	375	18	15	15
43	412	18	15	15
44	450	19	15	15
45	487	19	15	15
46	525	20	15	15
47	562	20	15	15
48	600	21	15	15
49	637	21	15	15
50	675	22	15	15
51	697	22	22	15
52	720	23	22	15
53	742	23	22	15
54	765	24	22	15
55	790	24	22	15

* Limited to five years

The maximum standard rates of retired pay and the compulsory retiring ages for the several ranks are

Rank	Yearly rate of retired pay	Compulsory retiring age
	£	
Air Vice-Marshal	1,010	60
Air Commodore	950	57
Group Captain	900	55
Wing Commander	600	51
Squadron Leader	500	48

Gratuities — A permanent officer allowed to retire before having qualified for retired pay may be granted a gratuity

provided he has not less than ten years' commissioned service, namely

£1,500	if he has 10 but not less than 15 years' commissioned service
£2,500	„ 15 or more than 15 „ „ „

Short-service officers will be eligible on passing to the Reserve for gratuities on the following scale £100 for each of the first two complete years of service, £150 for each of the third and fourth complete years, and £200 for the fifth complete year, that is

For three years' service on the active list	£350
For five „ „ „ „ .	£700

These gratuities will not be payable to officers granted permanent commissions, but their service on a short-service commission will count towards retired pay

CHAPTER XXIX

THE COLONIAL MEDICAL SERVICE

East African Medical Service—West African Medical Service—Eastern Medical Services—Other Colonial Medical Services—The Sudan Medical Service

MEDICAL practitioners deciding to enter the Colonial Medical Service will be well advised to make full inquiry as to prospects, pay and conditions of work. The various branches of the service do not offer equal opportunities, and before an intending candidate allows a private reason to dictate his choice—a thing which very often happens—he should make certain that he understands the chances before him in the particular country of his selection.

In the self-governing dominions, Canada, Australia, New Zealand, the Union of South Africa, and Newfoundland, and territories under their control, such as Papua and the Cook Islands, medical appointments are made concerning which information can be obtained from the High Commissioners or Agents-General in London, appointments in Egypt and the Sudan are regulated from the Foreign Office, in Southern Rhodesia the appointments are made by the local Government, and the High Commissioner's Office is at Crown House, Aldwych, in North Borneo application should be made to the British North Borneo Company, and those in Sarawak are in the hands of H. H. the Rajah. Much valuable information will be found in the *Professional Handbook*, Part II, issued by the Oversea Settlement Office, 3 and 4 Clement's Inn, London.

As a general rule, each Colony or Protectorate has its own public service distinct from that of every other, and it is usually only the higher officers who are transferred by the Secretary of State from one Colony to another. There are three exceptions to this rule. The West African Medical

Staff, which serves Nigeria, the Gold Coast, Sierra Leone and the Gambia, is one service The East African Medical Service, which serves the Kenya Colony and Protectorate, the Uganda, Zanzibar, Nyasaland and Somaliland Protectorates, the Tanganyika Territory and Northern Rhodesia, is one service In practice the medical services of the Straits Settlements and the Malay States may be regarded as one service

The Colonies, Protectorates and Mandated Territories to which medical officers are appointed by the Secretary of State for the Colonies are (A) The East African, (B) the West African, (C) the Eastern—viz Ceylon, the Straits Settlements and Malay States, Hong-Kong, Mauritius and the Seychelles, (D) the West Indian—viz British Guiana, Jamaica, Trinidad, the Windward Islands, the Leeward Islands, Barbados, British Honduras and the Bahamas, (E) Fiji and the Western Pacific, Cyprus, Gibraltar, St Helena, Bermuda and the Falkland Islands, (F) Palestine

In Ceylon, Mauritius, Jamaica, Barbados, the Bahamas, and Bermuda, vacancies are practically always filled locally by the appointment of qualified native candidates, or—in the case of some of the higher posts—by transfer from other Colonies Appointments in Malta are all filled locally Vacancies occur most regularly and frequently in the West African Medical Staff, the East African Medical Service, and the Straits Settlements and Malay States

The Sudan Medical Service is a separate organization

All applicants for medical appointments in the gift of the Secretary of State for the Colonies should be between the ages of twenty-three and thirty-five, and must be qualified and registered In the case of West Africa, preference will be given to candidates who are over twenty-five years of age, and in Fiji and the Western Pacific, to candidates who are under thirty Preference will be given to those who have held hospital appointments as house physicians and house surgeons, testimonials to character and professional competence will be required, and every officer before being

definitely appointed will be medically examined by one of the consulting physicians of the Colonial Office. Applications for appointments must be addressed to the Private Secretary (Appointments), Colonial Office, 38 Old Queen Street, London, S W 1. Candidates for appointments in East and West Africa are usually required to attend a course of instruction at the London or Liverpool School of Tropical Medicine before leaving this country. The gaining of the corresponding diploma will be a distinct advantage, as, of course, will be the possession of the D P H.

EAST AFRICAN MEDICAL SERVICE

Officers of this Service may be posted to any of the East African Dependencies, but their individual preferences are taken into consideration. Applicants must be British subjects of European parentage and between twenty-one and thirty-five years of age. Selected candidates are appointed as medical officers on probation for two years, after which their appointments are made permanent if their work has been satisfactory. Medical officers (but not sanitation officers) are permitted to take private practice at some stations, on the understanding that they give precedence to their official duties, but income from this source is not likely to be substantial, and the privilege may be withdrawn at any time. Where quarters or temporary accommodation are not provided free of rent the Government makes an allowance amounting to 15 per cent. of the initial salary of an officer's appointment. The salary of a medical or sanitation officer in Kenya, Uganda, the Tanganyika Territory, or Zanzibar is £600 per annum, rising by annual increments of £30 to £840, and thence by increments of £40 to £920, subject to an efficiency bar at £840. Senior medical officers and senior sanitation officers in these Dependencies are paid £1,000 a year, rising by annual increments of £50 to £1,100. The application of these scales to Nyasaland and Somaliland is under consideration, at present the scale for medical officers in these Dependencies is £600, rising by £25 to £900, with efficiency bars at £700 and £800. Those

who hold the Diploma in Public Health on entering, or who acquire it while in the Service, receive two special increments. Sanitation officers are selected from the ranks of medical officers as occasion arises.

The following appointments are attainable in Kenya, Uganda, and Tanganyika Territory: Director of Medical and Sanitary Services (£1,500), Deputy Director of Medical Services (£1,200), and of Sanitary Services (£1,200), and Director of Laboratory (£1,200). In Kenya and Uganda there are also Surgical Specialists (£1,200). In the other East African Dependencies there are fewer senior appointments and the salaries are slightly lower. Officers on the pensionable establishment retire on attaining the age of fifty years or after twenty years' East African service, whichever is earlier, but they may be retained in the Service, with their own consent, for a further period. Pension is calculated at the rate of one-sixtieth of pensionable emoluments—i.e. salary and value of free quarters—at the time of retirement, for every year of service, two years' service being reckoned as three years for this purpose. Any officer not wishing to wait to retire on a pension may leave the Service with a gratuity as follows: (a) After nine years' service (at least six in East Africa) £1,000, (b) after twelve years' service (at least eight in East Africa) £1,250. By accepting such a gratuity he forgoes claim to a pension.

Leave of absence on full salary is usually granted after about two years' residence. In most cases the allowance is six days for every month of service (or three days if the officer is not returning to East Africa), but the regulations vary for different stations. The period of leave does not include the voyage to and fro, for which full pay is also given. Free first-class passages are provided for the officer on first appointment and on leave, and in certain cases assistance towards family passages is provided.

WEST AFRICAN MEDICAL SERVICE

Candidates must be British subjects of European parentage. Their wish to go to some particular place will be

borne in mind by the authorities, but they are liable to be posted to any of the Colonies or Protectorates served by the West African staff. Transfers from one of these areas to another are made as seldom as possible and no one should apply for a West African appointment in the hope of being ultimately transferred. Passages for wives and children are not provided by the Government, and houses for the wives of junior medical officers are rarely available. Officers are not allowed to take their wives and young children out until they have acquired experience of the local conditions and obtained the sanction of the Governor.

Most of the officers of the staff are at present allowed to take private practice provided that it does not interfere with their official duties, but there are no opportunities for private practice at the majority of stations, and stations where such opportunities exist are allocated to senior men. Ordinary medical officers receive £660 a year, rising by annual increments of £30 to £720 a year. If their appointment is then confirmed, their salary becomes £720 a year, rising by increments of £40 to £960, with seniority allowance at the rate of £72 a year. Before passing £800 they are required to take a special course of study for three months, after which they must gain satisfactory certificates. A medical officer who has served for three years on the maximum salary of this scale (£960) without obtaining promotion is eligible to be placed on a higher scale.

The salaries of the senior officers are as follows. The Directors of the Medical and Sanitary Services in Nigeria, the Gold Coast and Sierra Leone receive £1,800, £1,600 and £1,400 respectively. The Deputy Directors in Nigeria receive £1,500, and the Deputy Director in the Gold Coast £1,400. In addition these officers have duty allowances ranging from £280 to £360 a year. There are nine assistant directors of Medical Services and several senior sanitary officials, all these have a salary of £1,300 a year and duty allowance of £260. Officers of outstanding professional merit are eligible for appointment as specialists at the same rate of pay, and after five years may be granted a

total remuneration of £1,680 a year At present five officers hold the rank of specialist in Nigeria and four on the Gold Coast Senior medical officers, of whom there are twenty on the staff, receive £1,000 a year, rising by annual increments of £50 to £1,150, and seniority allowance at the rate of £100 a year, whilst the six Senior Sanitary Officers are given £1,050 a year, rising by £50 to £1,200, together with duty allowance of £210 a year

Besides these there are several special appointments to directorship of research institutes, and about seventeen posts—mainly as medical officer of health—are filled irrespective of seniority, for these the salary starts at £800 and rises by annual increments of £40 to £960 a year, together with seniority allowance and staff pay amounting to another £212 Private practice is not allowed

Pensions and gratuities on retirement are granted in accordance with the law and regulations of each individual Colony Duty allowance, seniority allowance and staff pay are not pensionable emoluments Those transferred to pensionable Crown appointments elsewhere than in West Africa do not forfeit their claim to pension in respect of their West African service on final retirement if they have been members of the staff for at least twelve months

One week's vacation leave in the United Kingdom on full salary may be granted for every month of service in West Africa Time spent on the voyage or voyages does not count as vacation Such leave may be granted without any special grounds after eighteen consecutive months in West Africa, an officer will not be required to serve a tour of more than twenty-four months' residential service except in special circumstances, and the Governor may grant vacation leave to any officer at any time after twelve months' service Vacation leave on full salary may also be granted to an officer if he is invalided from West Africa after less than twelve months' residential service, and sick leave on full salary may be granted for any period not exceeding six calendar months

EASTERN MEDICAL SERVICES

In the Straits Settlements and Federated Malay States European medical officers are appointed at a salary of \$440 a month, rising to \$480 a month during three years' probation. If they are placed on the pensionable establishment, their salary then rises to \$500, and thence by annual increments of \$25 a month to \$800, with a strict efficiency bar at \$600. This scale of salaries has been fixed on the supposition that medical officers join the Service at about the age of twenty-seven. Above the concluding figure of \$800 a month there are certain higher appointments as follows: Principal Civil Medical Officer, Straits Settlements, and Principal Medical Officer, Federated Malay States, \$1,200 a month. Class A seven posts at \$1,050 a month. Class B nine posts at \$850, rising by \$30 to \$1,000.

Private practice by Government medical officers is not allowed. They may, however, receive fees for consultative work, if approved by the Government.

In the Malay Peninsula two months' leave of absence with full salary may be granted in respect of each year's service, and this leave may be accumulated up to a maximum of eight months. Additional leave on half-pay may be granted on special grounds. Up to the end of 1928 free passages are granted on first appointment and on leave, and free passages on first appointment or transfer are granted permanently for officers with salary under £800. With the consent of the Government an officer may retire at the age of fifty.

In Hong-Kong the present establishment of the Medical Department is: Principal Civil Medical Officer (£1,000–£1,200), eight medical officers (£600–£1,000), three port health officers (£600–£1,000), bacteriologist (£700–£1,000), two health officers (£600–£1,000) are also attached to the Sanitary Department. No free quarters, but in certain instances a rent allowance is paid by the Government.

OTHER OVERSEAS APPOINTMENTS

The Colonial Office has at its disposal medical posts in all the places enumerated under the headings D, E and F in the introductory part of this chapter. There are between thirty and forty medical officers in British Guiana, about forty-five in the Windward and Leeward Islands, and more than forty in Trinidad and Tobago. Private practice is allowed in many cases and the salaries are variable, sometimes appointments are filled by local candidates. In Fiji and the Western Pacific there are only a score of posts available, and chances of appointment to such places as St. Helena, the Falkland Islands, Cyprus and Gibraltar are few and far between. A fuller account of the medical establishment of these areas may be found annually in the Students' Number of the *Lancet*. In Palestine the grades and salaries of superior appointments in the Department of Health are: director, £E1,100-1,400, plus £E100 expatriation allowance, deputy director, senior medical officer (laboratory section), and senior medical officer (Jerusalem-Jaffa district), £E800-1,100, plus £E100 expatriation allowance, chemical analyst, three senior medical officers, and medical officer (Jerusalem-Jaffa district), £E550-750, plus £E50 expatriation allowance (£E1 = £1 0s 6d sterling). The remainder of the staff is recruited locally. The salaries of the two highest grades will be reduced as vacancies occur.

In most of the Colonies an officer holding a pensionable appointment may be allowed in the case of ill-health to retire on a pension after ten full years' resident service, otherwise he must have attained the age of fifty-five. For ten full years' resident service fifteen-sixtieths of the average annual salary of the retiring officer's fixed appointments for three years prior to retirement may be awarded, to which one-sixtieth may be added for each additional year's service, but no addition will be made in respect of any service beyond thirty-five years. In a few cases the retiring age is sixty, and the pension after ten years' service is ten-sixtieths instead of fifteen.

Leave of absence on half-salary is generally granted after a period of three years' resident service, and may be given sooner in case of serious indisposition, or of urgent private affairs. In the absence of special grounds the leave must not exceed one-sixth of the officer's resident service. In addition to the above, vacation leave on full pay may be granted, if no inconvenience or expense is caused thereby, not exceeding three months in any two years, or, in the case of Fiji and the Western Pacific and the Falkland Islands, four and a half months in any three years. In British Guiana there are other arrangements.

On first appointment an officer will in most cases be provided with free passages for himself and his wife and children, if any, not exceeding four persons besides himself. The officer so appointed will have to repay the cost of such passages if he leaves the Government service within three years. An officer taking leave out of the Colony usually has to provide his own passages.

SUDAN MEDICAL SERVICE

The staff at present consists of a Director (£1,500-£1,800), a Senior Physician and a Senior Surgeon to the Khartoum and Omdurman Civil Hospitals (£1,200-£1,750), an Assistant Director and Medical Officer of Health, Khartoum Province (£1,200), and twenty-four senior medical inspectors and medical inspectors, who are all British. The pay of the inspectors commences at £720, and rises by five biennial increases to £1,080, and thence, after thirteen years' service, to £1,200. All medical inspectors are appointed on probation for two years. The remaining posts in the Service are filled by non-Europeans.

Among the attractions of the Service are the annual leave of ninety days for every year's service, which under ordinary circumstances is granted each year, study leave for some definite purpose, and two years granted towards pension to those who have obtained special qualifications and experience. The pension for a medical inspector retiring after twenty years' service is, as a rule, not less

than £500 a year. Private practice is limited to a few of the larger towns. The duties of the Service include acting as consultant to the principal hospitals, and supervising smaller hospitals or dispensaries, initiating and supervising the medical and sanitary work of a province, the medical supervision of schools, the examination of candidates for Government service and pension, and the training of assistant medical officers and native sanitary overseers. In the Khartoum medical school there are opportunities for teaching. The country is developing rapidly, and the Medical Department is being enlarged to meet the increased requirements of the Service.

Candidates for the Service must be single and under thirty years of age, and must have held a resident post, preferably that of house surgeon, in a large general hospital. They are required to take a course of tropical medicine. Further information may be had from Dr Acland, 19 Bryanston Square, London, W 1.

CHAPTER XXX

THE CIVILIAN PUBLIC SERVICES

The Public Health Service—Staffing of Appointments · Assistantships—Graded Salaries—Equal Pay for Women

THE special diplomas serve, as has been indicated, the general purpose of demonstrating that a practitioner has worked along certain lines in an intensive way, and the particular one of securing for their possessors advancement in the Fighting and Colonial Services. In the career of the civilian medical man, which remains for notice, they also play a part.

There are certain places in which the diploma is a necessity for high posts in a service, and this is notably the case with the D P H—the one registrable diploma. Those, however, who take up public health work as a career themselves fall into certain categories, closely or loosely associated, and for the auxiliary or concomitant work in the health service the D P H is also desirable. Though school medical officers are appointed to carry on the machinery for medical inspection under the Board of Education, they generally possess, and will always find it of great advantage to possess, the D P H. For the school medical officer is frequently an assistant medical officer of health for education purposes, and in many localities the chief medical officer of health is his own school medical officer. Again, the tuberculosis officer is usually on the general public health staff, and while the diploma in the medicine of tuberculosis might here be useful in obtaining such a post, the practitioner would certainly be wise to acquire the D P H, which would enable him to fill a larger office in the service if opportunity arose. Where the venereal disease officer is a member of the public health staff he should for similar reasons possess the D P H.

THE PUBLIC HEALTH SERVICE

Medical officers of health are either whole-time or part-time. We are here concerned with the whole-time service, which conforms more or less to a uniform pattern and in which a scheme for remuneration and promotion of a symmetrical character can be put into action.

For some reason which is difficult to explain the remuneration of public health appointments has never yet borne any reasonable relation to the earnings of practitioners in other branches of medicine. In spite of this fact many good men are attracted to a service which offers unique opportunities of advancing the well-being of the community. The work accomplished by the pioneers during the last half-century met with scant recognition, although the results they achieved brought about a spectacular reduction in morbidity and mortality. Of recent years there has been legislation involving a remarkable extension in the provision of public health medical services, and the men who had been mainly concerned with environmental hygiene, find themselves responsible for the medical supervision of school-children, the welfare of mothers and infants, the organization of clinics for the treatment of defects and minor ailments, and the administration of schemes for the control and treatment of tuberculosis and venereal diseases. It was when they realized how closely the public health department must be brought into contact with the private practitioner that medical officers of health became uneasy about the staffing of the service. While they had been content to accept almost contemptuous salaries themselves, it dawned upon them that for the extended activities of their departments they must have assistant colleagues of good standing who would command the confidence of the public and the respect of the private practitioner. It meant, in fact, that in order to attract and retain such assistants, the service must offer salaries comparable with the rewards of other branches of practice. A campaign for fair salaries in the public health service was initiated and carried through.

mainly by senior medical officers of health who could expect no personal gain from the result of their efforts

Staffing of Health Departments

The majority of the medical officers who have chosen the public health service as a career are real enthusiasts, and if they magnify their office it is because they fervently believe that the future belongs to preventive medicine. But they know well enough that the influence of the health department cannot reach its maximum until every private practitioner is cooperating for the prevention of disease. Hence their anxiety to attract promising young graduates to the public health service, men with qualifications and experience that will secure the confidence of their colleagues in private practice. They would like it to be recognized by the medical schools that the extension of preventive medicine calls for the best brains of the profession, more especially as the health officials in their relation to local authorities can do much to instruct lay opinion on medical matters. It is not enough, however, to offer a young doctor work of extraordinary interest and influence, if he is to accept the limitations of an official post he is surely entitled to an adequate salary with reasonable prospects of advancement. Otherwise the public health service must be staffed by men with private means, by men with no ambition, or by men who have failed in other branches of practice.

Before the great extension of health services there were so few assistant medical officers of health that all of them might expect to secure promotion to a principal post in the course of time. To-day things are very different, for in the counties and big cities, in addition to deputy or assistant medical officers of health for general administrative purposes, there are assistant medical officers for the specialist branches already mentioned. Obviously, only a small percentage of these assistant medical officers can become medical officers of health, and a principal consideration with the Society of Medical Officers of Health has been to devise a graded list of appointments that would encourage experienced men to

remain in the service. It should be recognized, therefore, that we have now in the public health service two types of assistant, although in the smaller areas one medical man may combine the duties of both. But it seems likely that the types will become more and more distinct as the organization of the public health service develops, and we may consider here the training and experience which should be expected of candidates for these posts.

Assistantships in the Service

Administrative Posts —The young medical graduate whose ultimate ambition is to become a medical officer of health has several years' work ahead of him before he can expect his first appointment. Under the new regulations of the General Medical Council he cannot acquire the D P H or other specialist qualification in State medicine until two years after qualification. Also he should hold resident appointments in hospitals, especially those devoted to women and children, and to the treatment of ear, eye, nose, throat and skin affections—all this in order that later on he may be competent to administer the various health schemes of his local authority. It is possible to combine some of these appointments with study for the D P H. It is also advisable that he should serve for six months or so as assistant to a busy general practitioner, so that he may realize the difficulties to be contended with in that field. Even then he should extend his experience by entering as a resident medical officer at a municipal fever hospital or tuberculosis sanatorium. It will be seen, therefore, that the medical man who wishes to equip himself thoroughly for the highest administrative posts in the public health service will not complete his full training much before his thirtieth year.

Specialist Posts —Although a public health qualification is not essential for those entering specialist branches of the service it is very desirable, for even the clinical activities of the health department should be based on the general scheme for the prevention of disease. A candidate for the posts will follow the usual course of training for the particular

branch of work by residence and attendance at the appropriate special hospitals. If he is wise, and if he hopes to obtain a senior post in the public health service, he will take one of the higher qualifications in medicine or surgery, for the value of the specialist medical officer depends very much on the confidence he inspires amongst the private practitioners in his area. Hitherto these posts have been so badly paid that the claims of the men appointed to be regarded as specialists have sometimes been very slender, so that the experienced general practitioner has felt no great respect for suggestions coming from the public health department. It was in order to attract highly qualified men for these clinical posts that the Society of Medical Officers of Health decided it was necessary to grade the appointments and to obtain for those who hold them reasonable prospects of advancement on the lines indicated below.

Minimum Commencing Salaries Promotions and Increments

The Society contends that highly trained men are required for these posts and that the right type of candidate will be nearly thirty years of age before he is ready for his first appointment. It has recommended that the minimum commencing salary should be £600 per annum, on the understanding that entrants must have had three years' professional experience subsequent to obtaining their registrable qualification. This recommendation has been adopted by the British Medical Association, and advertisements offering less remuneration for assistant posts, as a rule, are no longer accepted by the professional journals. Local authorities are realizing that this establishment of a minimum salary of £600 is reasonable, and that their health departments lose prestige when appointments are not approved by the representative bodies of the profession.

The £600 minimum applies only to a junior assistant working under the medical officer of health, or under a senior medical officer. The latter category includes those medical officers who are in charge of departments (e.g. schools, tuberculosis, venereal diseases, maternity and child

welfare, mental deficiency) and who are directly responsible to the medical officer of health, or, more rarely, as in the case of some school medical officers, to a committee. The minimum commencing salary for these senior medical officers is fixed at £750 when single-handed, rising to £1,100 for those with six assistants, with increments of £50 for each additional two assistants. In the case of a deputy medical officer of health, duly appointed to assist his chief in the general administration of the health department, the minimum commencing salary must be equal to 50 per cent of the salary of the medical officer of health and not less than the salary of the next grade of medical officer in the department. Finally, we have the scale for medical officers of health commencing with a minimum of £800 in areas where the population is less than 35,000, and ascending by graded increases to £1,800 for populations exceeding 600,000. The scale has been widely circulated in the professional journals, and it is understood that the salaries are subject to no deduction, expenses being met by the authorities.

Where the school medical officer, the tuberculosis medical officer, and the officer under the Public Health (Venereal Diseases) Act, 1916, schemes are members of the staff of the medical officer of health, their salaries should be graded in accordance with the above figures. The medical officers for maternity and child welfare purposes are also, as a rule, assistants to the medical officer of health, receiving from the local authorities comparable salaries. In each case the salary should be dependent on the work to be done, and especially on how far the officers fill the position of chief of their departments. It is clear that the possession of the D P H would be an advantage to all, while those associated with the clinics for the treatment of eye, ear or throat defects are advised to secure special diplomas.

EQUAL PAY FOR WOMEN

As will be seen, modern development in preventive medicine offers an increasing number of full-time posts with definite salaries to both qualified men and women, and

this will be a convenient place to refer to the general consensus of opinion that salaries should be paid without reference to the sex of the worker. When the minimum scale of salaries in the public health service was decided upon there was a confusion, intentional or unintentional, in the minds of some of the authorities, in whose hands lies the filling of the offices, as to what that minimum was, owing to a general conclusion, previously arrived at, that £500 a year was the least payment for whole-time work that should be accepted, either by fully qualified men or fully qualified women. When the minimum was settled for the public health service at £600, coupled with the recommendation that no one should be appointed without at least three years of qualifying post-graduate work, certain of the authorities issued advertisements for medical women at the lower salary and without the conditions as to post-graduate work. This was a multiple weapon against the higher standardization of medical work. If the posts were filled at the inferior salaries men would be either superseded or would have to take lower terms. If the women remained firm there was the risk that on equal terms, and mainly out of conservatism, the men would be preferred, and if the women yielded and the men followed suit the valuable measure of progress indicated by the necessity for post-graduate training would stop short.

The Medical Women's Federation took immediate steps. This body includes about 1,100 women in practice and many associated students, and the constituency was united in believing that equal pay for equal work must be insisted upon. In all known cases where the lower salaries had been accepted by women the Medical Women's Federation wrote acquainting the women with the facts, and numbers of women to whom a post at £500 a year would have been a coveted prize ceased to apply, an act of self-sacrifice which all will recognize. Some had accepted posts before knowing the real situation, and had involved themselves in financial responsibility, and it may be added that, although some advertisements for junior whole-time appointments had

asked for women only, the numbers of men and of women who have accepted underpaid posts are about equal

As the course of training, the diplomas taken, and the work done in public health appointments are the same for women as for men, any attempt to pay the former less is unjust and illogical. Also, it is impossible to lower the standard of pay given or the experience demanded from any one group in the profession without creating profound changes of some kind or another. There is no doubt that women do the work as well as their male colleagues in the posts that they have been chosen for, and if women accept lower salaries the authorities will be quick to recognize that, by employing women, they can obtain as good an officer in certain directions with economy of expenditure. There is a need for the utmost loyalty from every member of the profession, because what is at stake is not merely a question of money, but the right of the medical profession, who are trained in matters which pertain to the health of the community, to advise as to the experience necessary in health officers, and the salary which can reasonably be expected to attract the right people.

Women cannot win this battle alone. If the posts they refuse can be filled by men, their resistance will clearly mean the gradual exclusion of women from the public health service, and this, it is acknowledged upon all hands, would be deplorable.

CHAPTER XXXI

THE CIVILIAN PUBLIC SERVICES (*continued*)

The Poor Law Medical Service—Opportunities in Psychiatry
—The Prison Medical Staff

THE POOR LAW MEDICAL SERVICE

MANY developments are taking place in the organization of medical relief now provided by Poor Law Authorities, and legislation is due for the transference of the functions of existing Poor Law Authorities to County and to County Borough Councils. The prospects of those entering the Poor Law Service cannot therefore be defined precisely at the present moment, but it is clear that they will not be less attractive than they are at present, while the number of responsible, whole-time appointments will doubtless continue to increase.

The Domiciliary Medical Service

For the provision of domiciliary medical attendance on the poor, England and Wales are divided into between three and four thousand medical relief districts, to each of which a District Medical Officer responsible for attending on the sick poor in his district is appointed by the Poor Law Authority for the area. He is usually paid a modest salary for part-time employment, but in some instances whole-time officers have been appointed for this work, either alone or in combination with some other public medical appointment, such as public vaccinator or medical officer to some Poor Law institution. Surgery accommodation is usually provided by the guardians. The salary for these posts, which are not numerous, ranges from £500 to

£800 a year The appointments are made by the guardians for the area The officers are pensionable and cannot be dismissed without the consent of the Minister of Health

The Institutional Medical Service

One of the most important functions of Poor Law Authorities is to provide residential treatment for the sick poor In the smaller and less populous areas this is done by the assignment to the sick of a portion of a large "General Institution," this being now the official designation of a Poor Law Workhouse In large urban districts and in certain populous rural districts provision for the sick takes the shape either of a separate infirmary in charge of a medical superintendent or of the infirmary section of a general institution in medical but not, as a rule, in administrative charge of a medical officer The medical officers of the smaller institutions are usually non-resident, part-time general practitioners, but most of the medical superintendents of the separate infirmaries and many of the medical officers of the larger infirmaries are whole-time officers, aided, as far as necessary, by assistant resident medical officers and in many instances by a visiting consultant staff. In England and Wales about eighty infirmaries are now in charge of whole-time medical officers, and the number tends to increase with the greater demand for residential treatment

Clinical Opportunities

The medical and surgical work of the larger Poor Law infirmaries differs in no essential from that of a large general hospital, except that, owing to the legal obligations of the guardians, beds have to be found for a much higher proportion of patients suffering from chronic diseases, from minor ailments, and from the disabilities of old age than would be the case in a general hospital Large numbers of maternity patients are also admitted Latterly the amount of acute work has increased, partly on account of more frequent resort to surgical interference and partly through increased

public appreciation of the quality of the medical and nursing service available in modern infirmaries. In one large infirmary over 1,100 abdominal operations, exclusive of 38 hysterectomies, 54 ovariectomies, and 6 caesarean sections were undertaken in one year. So much is this increased call upon the infirmaries the case that in several areas the Poor Law Authorities have made special arrangements for the admission of so-called "private" patients who are willing to pay the full cost of treatment.

Apart from ordinary medical and surgical work, Poor Law infirmaries afford an almost inexhaustible storehouse of rare clinical material. This is specially so in the case of nervous diseases, and of the more chronic general diseases. There are therefore ample opportunities for clinical and pathological research, while the variety of clinical experience affords a better preliminary training for the general practitioner than can be obtained in most general hospitals. This is being recognized and many medical schools are now arranging for their students to attend demonstrations at the Poor Law infirmaries on types of cases not commonly met with at general hospitals. The value of a temporary post at an infirmary as part of general training is not, however, as fully appreciated as it should be.

Professional Prospects

The medical officers of infirmaries are appointed by the guardians of the Union, are pensionable and, in the case of principal medical officers, cannot be dismissed without the consent of the Minister of Health. In most instances there are residential emoluments, comprising full board and residence for the junior staff, and a house and certain other allowances for the principal medical officers. Usually the guardians have unfettered discretion in the selection of officers, but in some cases there is a requirement that candidates for the post of medical superintendent must have been registered for five years, have held a resident post at a general hospital, and had some experience of administration. Vacancies are usually advertised in the medical

press There is no fixed scale, but the salaries (inclusive of the estimated value of any emoluments) paid to the principal medical officers vary from £650 to £2,000 a year. Amounts in excess of £1,500 are, however, paid in very few areas, while the maximum of £2,000 is given to a Medical Superintendent who also acts as the Chief Medical Officer of a large Union The tendency is for salaries to rise as Poor Law Authorities are recognizing the importance of attracting and retaining well-qualified officers The junior medical officers are usually paid about £300 to £500 a year, together with free board and residence In some instances smaller salaries are paid to men and women of the house physician type, while as much as £700, rising to £1,000, may be paid to the responsible chief assistants in large infirmaries In a few instances assistant medical officers live outside the institutions and are paid £700 to £900 a year for whole-time services

Special Institutions the Metropolitan Asylums Board

In addition to the general infirmaries to which reference has hitherto been made, Poor Law Authorities administer various special institutions, including several children's hospitals, and certain institutions for defectives and other mental patients In the case of the children's hospitals the status and emoluments of the medical staff are similar to those obtaining in general infirmaries

In London the Metropolitan Asylums Board, which is a Poor Law Authority, provides hospitals for patients suffering from fevers and from smallpox, though these patients are by statute exempted from the disabilities attaching to persons in receipt of poor relief There are some twenty hospitals of this kind The Medical Superintendents receive salaries rising from £900 to £1,150, together with an unfurnished house The junior medical officers are of three grades, and are paid from £500 to £750 a year, inclusive of residential emoluments

In the provinces fever hospitals are provided by the local Sanitary Authorities, and are often in administrative

charge of the Medical Officer of Health. Few provincial fever hospitals are sufficiently large to offer attractive, permanent, whole-time posts.

OPPORTUNITIES IN PSYCHIATRY

A recently qualified medical man, or woman, who is seeking an opening will do well to consider the increasing field offered by the study and practice of psychiatry. Here one qualification is essential, and that is the right temperament. Only experiment can determine the suitability of a practitioner for work among the insane. Six months' residence in a mental hospital will be valuable experience whatever his future, and should be quite long enough to satisfy him concerning his fitness for such service.

The man who contemplates psychiatry as a career should commence by filling one or more house appointments at a general hospital—if possible, one to which a teaching school is attached—after which he can choose from a variety of courses. He can enter a public mental hospital, a registered hospital, such as Bethlem Royal Hospital, or one of the Royal Asylums in Scotland, or he can take an appointment in a private institution. The rates of pay and emoluments will vary somewhat.

The London County Mental Hospital Service

An example may be given of the conditions in the London County Mental Hospital Service, where large opportunities are given to those who enter it, but the information is pertinent wherever the start is made.

This authority is responsible for nine institutions near London, not including the Maudsley Hospital, which deals with voluntary patients only, and which offers new opportunities for the study of early mental disease. The medical staff of these large hospitals consists of a Medical Superintendent, a Deputy Superintendent, and seven other assistant physicians. Vacancies are advertised in the medical journals, and a registrable medical qualification is, of course,

necessary to obtain a junior post In the L C C Service the pay commences at £300 per annum, rising by £25 a year to £400 To this must be added a temporary addition on the Civil Service scale, which is, roughly, one-third of the salary A deduction of about £100 per annum is made for board and lodging Having obtained a junior appointment effort should be made, where this is possible, to secure honour qualifications, and the Diploma in Psychological Medicine must be obtained if promotion is desired The L C C Service gives special facilities for all junior medical officers to take courses of study for this Diploma Facilities are given also for junior physicians to receive training in the excellent laboratories at the Maudsley Hospital Promotion is made as vacancies occur, from the Service generally, and is not confined to the staffs of the hospitals at which vacancies happen to arise

The third and fourth assistant physicians receive £425 per annum, rising by £25 per year to £500 A second assistant physician commences at £525, rising by annual increments to £600 per annum, and a Deputy Superintendent receives £700 per year The yearly pay of a Medical Superintendent is £1,200, together with unfurnished house, rates, taxes and water supply free All these salaries carry with them an addition on the Civil Service scale, which is subject to reduction according to the cost of living Contributions are made to a superannuation fund, and as pensions may be drawn by superintendents from the age of fifty-five, vacancies for the senior posts occur with moderate frequency Most senior officers are married and have houses on the estates Permission is given for a married physician to reside outside the hospital if accommodation is lacking, but he is expected to take his turn of resident duty from time to time Promotion depends on the ability and energy of the officer

Professional Prospects in Psychiatry

Having obtained a senior post in a mental hospital service such as London possesses, a physician may successfully

apply for posts in the hospitals of other county authorities. The position of medical superintendent in most county hospitals is worth from £900 to £1,200 a year according to the size of the hospital, in nearly all cases a house is provided, and in many there are extra emoluments. Outside the London area the assistant medical staff is smaller, but the rates of pay are closely similar. A junior assistant receives about £300 as salary, and usually board, lodging, laundry and attendance in addition, but the Civil Service bonus cannot be counted upon. First, and often second, assistant physicians in county hospitals are married, and have the use of a house on the estate. Their pay ranges from £500 to £800 yearly, but here there are considerable variations. Some county authorities appoint pathologists to a group of hospitals, who receive from £500 to £700 a year, and may also be provided with a house in addition. All these appointments are pensionable.

The physician in a registered hospital deals with patients drawn from the upper and middle classes, and the domestic environment is made attractive. A junior member of the staff would receive from £250 per year, reaching £800 in the case of a senior assistant, who generally gets a house, and is able to marry. The post of superintendent is in some cases valuable, while experience at such institutions is of great use, especially to a physician who aims at establishing a consulting practice. The same is true of a good private institution, and at the old-established Royal Asylums in Scotland. But promotion is slow in such hospitals, and only hard work will enable a physician to compete successfully for vacancies at institutions other than his own.

There is no royal road to consulting practice. Long years of clinical experience are essential, and every opportunity should be sought of obtaining a teaching appointment. For senior and specially qualified practitioners in the speciality there are the possibilities of being selected as a Commissioner or a Visitor to the Lord Chancellor.

There is increasing scope for clinical work, laboratory research, psycho-pathological investigation, and the study

of the problems of prevention Mental hospital service offers reasonable financial prospects, and opportunities for marriage There are, further, growing opportunities in this service for women practitioners Study leave is being granted much more freely, and prospects of promotion are greatly increased for those who make full use of the chances The possession of the Diploma in Psychological Medicine is essential in all the senior posts, and a practitioner should spare no effort to obtain honour qualifications if he does not possess them

PRISON SERVICE MEDICAL STAFF

This is a small staff and the work is special, but in these days its connexion on the one hand with public health, and on the other with psychiatry, is fully recognized, and there is no doubt that the position of the medical staff in the Prison Service will gain in status as the service generally follows its present and right tendencies towards the recognition of the medical side of criminology

There are whole-time and part-time officers The part-time officer discharges the necessary duties in small prisons, the appointments being usually filled by local practitioners, and being terminable at any time without title to pension The salaries here are from £110 to £300 per annum, according to the population of the prison The whole-time officers are divided into two classes, principal or chief officers and assistants The principal officer is responsible for the performance of all duties in the prison according to statutes, rules and regulations, but in his absence, where a prison possesses both officers, the assistant performs the duties

The applications for appointment as medical officer, Class II, must be accompanied with satisfactory evidence that the candidate is over twenty-three years of age, a registered practitioner of sound health, and impeded by no imperfection likely to interfere with the efficient discharge of his duties He should be under thirty years of age, and should furnish particulars of any appointments he may

have held, for preference is given to those candidates who have held the post of house physician or surgeon at a large hospital, or who have had experience in lunacy or public health work. It goes without saying that if he possesses the D P H or the special diploma in psychiatry his chances will be by so much the better.

The candidate, on being appointed, is considered on probation, subject to a report at the expiration of six months as to the manner in which he has discharged his duties, while a further report will be made upon him on the completion of two years' service. The salaries in Class II range from £350, by annual increments of £20, to £600, while the salaries in Class I, commencing at £650, range from this figure, with annual increments of £25, to £800. In many cases quarters are supplied, but when these are not available allowances are granted in lieu, and in both classes the officers are entitled to a statutory pension under the provisions of the Superannuation Acts. In addition to the scales of pay set out above a temporary bonus is granted which varies in accordance with the rise or fall in the cost of living.

PART VI

APPENDIX

I —BOOK-KEEPING

To the average medical man book-keeping is a subject which suggests a great expenditure of time and energy in compiling columns of figures, totals and cross totals, with very doubtful corresponding advantage. It is quite possible, however, to reduce the clerical labour to very reasonable proportions, and to preserve the essentials in a simple and straightforward manner. It is hoped that the suggestions now to be outlined will enable the practitioner to record his financial progress for his own information and that of possible future partners or successors, and also to meet the Inspector of Taxes with accounts which can be certified as representing faithfully the profit.

The transactions necessary to be recorded may be divided into two classes. Firstly, transactions affecting the cash received before it has been banked, and secondly, transactions through the bank. The latter class of transaction is recorded by the bank itself in the Bank Pass Book, but the former class is naturally not so recorded.

A Cash Book should be kept for the purpose of this record, which, together with the Bank Pass Book and the list of outstanding accounts at the close of each year, will furnish the material required for the preparation of the Final Accounts.

The Cash Book —The form for this book is shown in

Table I The debit side will have three columns, headed

- (1) Cash Takings
- (2) Credit Account Takings
- (3) Total

The total column will give all cheques and cash received of any description. These will consist of fees received at the time that treatment is given, incomings in settlement or on account of outstandings, and all other receipts which are not of a business nature, such as rents, interests and dividends received. The cash and credit receipts will be analysed under their respective columns, but there will be no necessity to analyse private receipts, as they will not come into the Final Account. The Credit Account Takings will be posted in detail to a ledger, or such record as is found most convenient. The record may be in the nature of a Day Book or a Ledger recording all charges in respect of patients who have Credit Accounts, and will be marked off or cleared as payments are received. The two analysis columns on the debit side of the Cash Book will be totalled through to the end of the year. If the Ledger is adopted a small loose-leaf book will be found particularly useful, being inexpensive, compact, and easily adapted to all possible requirements.

The credit side of the Cash Book should have one total column and as many analysis columns as may be found desirable, such as Paid to Bank, Wages, Postages and Stamps, Repairs and Renewals, Car Expenses, Sundry Expenses, Personal, etc. Analysis Cash Books with three debit columns and six to ten credit columns are stocked by all well-known account-book makers or may be obtained through any stationer. It should be particularly noted that the entries on the credit side of the Cash Book are intended for cash payments only, as all cheque payments will be recorded in the Bank Pass Book and there is no need for duplication. It will therefore considerably lessen the book-keeping if all possible expenses are paid by cheque, and as such expenses as Rent, Rates, Gas and Telephone are

usually paid in that manner, Sundry Expenses should form the main items to be recorded in the Cash Book Sums paid to bank will also be entered and analysed under the "Paid to Bank" column It will now be seen that the Cash Book will show receipts from all sources (includ-

TABLE I—CASH BOOK

Dr

Date	Detail	Fo	Cash Takings			Credit Account Takings			Total		
			£	s	d	£	s	d	£	s	d
19											
Mar 31	To Balance of Cash in Hand								£ 2	10	0
Apl 1	„ R M Takings		2	0	0						
„	„ J (Credit %)	3				2	2	0	5	13	6
„	„ H (Credit %)	7				1	11	6	10	0	0
„ 2	„ Interest on A s Shares								10	0	0
„	„ Cheque from Bank								8	10	0
„	„ Rents received								1	8	0
„	„ R M Takings		1	8	0				19	10	0
„	„ H (Credit %)	6				19	10	0	57	11	6
									2	2	0
„ 3	„ Cash in Hand	b/d									
	Totalled through to end of year		400	0	0	1,300	0	0			

ing cash and cheques), and all cash payments and lodgements to bank The balance at any time will therefore represent the balance of cash in hand unbanked at that time

The analysis columns should be totalled from time to time and ultimately to the end of the year

Final Account—The Final Account will be in the nature of an Income and Expenditure Account, and the procedure for its compilation will be as follows

1 Obtain the Bank Pass Book from the bank and analyse all the expenses relating to the business under appropriate headings The analysis will be in the form as shown in Table II, further columns being added as desired, such as for stationery, travelling other than by

car, specialist's fees, postages, personal drawing and/or expenditure

2 Extract from the Day Book or Ledger a list of all unpaid accounts at the end of the financial year

3 Make up the Final Account as shown in Table III

TABLE I—CASH BOOK

Cr

Date	Detail	Paid to Bank			Wages			Post ages & Stamps			Repairs and Re newals			Car Ex penses			Sundry Ex penses			Per sonal			Total		
		£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d
19																									
Apl 1	By Stamps							0	10	0							0	2	0				0	10	0
" "	" Fares																						0	2	0
" 2	" Bank	3	13	6																			3	13	6
" "	" Wages				4	0	0																4	0	0
" "	" Petrol, etc													3	4	6							3	4	6
" "	" Stationery																1	3	0				1	3	0
" "	" Lino for Surgery										3	6	0										3	6	0
" 3	" Bank	29	10	0																			29	10	0
" "	" Drawings or private payments																			10	0	0	10	0	0
" "	" Balance of Cash in Hand																						2	2	0
																							57	11	0
(Note—No cheque payments to be entered in this book)																									
	Totalled through to end of year	2,000	0	0	208	0	0	30	0	0	18	0	0	52	0	0	28	0	0	400	0	0			

The receipts for the Final Account will be obtained from the Cash Book as follows

Cash receipts (as per total of analysis column)		£400
Credit receipts (as per total of analysis column)	£1,300	
Less outstanding accounts as at date of last account (as per list extracted from the Day Book or Ledger at that date)	100	
	<u>£1,200</u>	
Add outstanding accounts as at date of closing the account under consideration (as per list extracted from the Day Book or Ledger at that date)	120	
	<u>1,320</u>	
		£1,720

The expenditure will be obtained from the two analyses—the Cash analysis recorded in the Cash Book, and the Cheque

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analysis extracted from the Bank Pass Book, as under

Rents (as per Pass Book analysis)	£40
Rates and Water (as per Pass Book analysis)	31
Telephone	
(As per Pass Book analysis)	£15
(As per Cash Book analysis)	7
	22
Postages and Stamps (as per Cash Book analysis)	30
Repairs and Renewals	
(As per Pass Book analysis)	26
(As per Cash Book analysis)	18
Car Expenses	44
(As per Pass Book analysis)	112
(As per Cash Book analysis)	52
	164

and so on, combining the two analyses

The balance of the account will show the net profit of the business for the year

TABLE II—ANALYSIS OF BUSINESS EXPENDITURE EXTRACTED FROM BANK PASS BOOK

Year ended 31st March, 19

Drugs, Instruments and Bottles, etc			Rent			Rates and Water			Gas and Electricity			Telephone			Insurances			Car Expenses			Repairs and Renewals		
£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d	£	s	d
2	5	0	10	0	0	12	10	0	5	10	3	3	18	0	21	0	0	16	5	0	13	8	9
3	8	0	10	0	0	3	0	0	4	0	6	3	13	6	2	8	0	2	4	0	2	4	7
4	0	0	10	0	0	12	10	0	3	15	9	4	2	8				7	0	8			
	etc		10	0	0	3	0	0	5	13	6	3	5	10				23	10	6			
55	0	0	40	0	0	31	0	0	19	0	0	15	0	0	23	8	0	112	0	0	26	0	0

TABLE III—INCOME AND EXPENDITURE ACCOUNT

Year ended 31st March, 19

Dr	Expenditure	£	s	d	Income	Cr
						£ s d
To Wages (including Keep)		260	0	0	By Fees Receivable	1,720 0 0
„ Drugs, Instruments and Bottles		55	0	0		
„ Rent (or net Schedule "A")		40	0	0	(Note	
„ Rates and Water		31	0	0	Fees from public appointments	
„ Gas and Electricity		19	0	0	may be shown separately if desired)	
„ Telephone		22	0	0		
„ Insurances		23	8	0		
„ Car Expenses		164	0	0		
„ Repairs and Renewals		26	0	0		
„ Postages and Stamps		30	0	0		
„ Sundry Expenses		28	0	0		
„ Net Profit for the year		1022	0	0		
		£1,720	0	0		£1,720 0 0

II—INCOME TAX

A system of book-keeping having been explained, it is now proposed to consider the Income-Tax assessment, and the deductions, allowances and reliefs which may be claimed. These do not depend upon the manner in which the accounts have been kept provided that the receipts and expenses have been duly recorded, and that the profit is clearly ascertainable.

Computation of Income-Tax Assessment

For the purposes of Income-Tax assessment it is permissible to include salaries from public appointments in the assessment on the practice generally. This point has been provided for in the preparation of the final account, and proves of advantage inasmuch as one demand only is received instead of a number varying with the number of sources of professional income. Such emoluments may be assessed separately, and in partnerships this course may be desirable. The final account should show no private payments except those which it is impracticable to separate from business payments. These would consist of such items as rent, rates, repairs, insurance, lighting and heating where the practice is conducted from the residence, which is, of course, quite usual. In these circumstances the computation of the profit liable to assessment would be in the following form.

	£	s	d	£	s	d
Balance per account				£1,022	0	0
Add back to profits						
Half Rent (or Sch "A")	20	0	0			
Half Repairs ¹ (say)	5	10	0			
Half Lighting and Heating	9	10	0			
Half Rates, etc	15	10	0			
Half Insurance (excluding Life Assurance)	1	10	0			
Private use of Car (say)	40	0	0			
Additions to Instruments, Furniture, etc ¹ (say)	10	0	0			
				102	0	0
Adjusted profit for 1925-26				£1,124	0	0

¹ Renewals for the practice are allowable

The year of assessment begins on April 6, and if a practice commences on or subsequent to that date the first year's assessment is based upon the profit from the date of commencement up to the next April 5, the second year will be a twelve months' proportion of the first period, and the third year will be based on the average of the two preceding periods. The subsequent years' assessments are arrived at on the well-known basis of the three years' average, which, however, will cease to operate as from April 1927. Years subsequent to 1926-27 are dealt with later. The calculation of the assessment for years up to and including 1926-27 would be as follows

1925-26—Profit as above		£1,124
1924-25—Adjusted profit previously agreed	(say)	1,000
1923-24— " " " "	"	1,000
		<hr/>
		3)3,124
Average for 1926-27		£1,041

It should be mentioned that the proportion of private expenses added back to profits is not uniformly one-half. The General Commissioners vary considerably in their views, but the practice in and about the City of London appears to be to add back one-half, with the result that the other half of such expenses has in effect been allowed as a business charge. It is not easily understood why this practice is not adopted generally (particularly in the provinces) where the practice is conducted from the residence, and it appears to be a point worthy of the attention of medical practitioners' associations. It is, of course, understood that where the premises are used for the practice only, and not for any private or domestic purpose, the whole of the expenses are chargeable.

Prior to the Finance Act, 1925, the right to claim car wear and tear was confined to traders and manufacturers, but a practitioner may now claim the allowance. It is in the form of a percentage calculated upon the written-down value of the car. The rate is usually 15 per cent, but is

liable to variation It is an alternative to a claim for the cost of car renewal, which is allowable to the extent of the value replaced less the amount received on sale or exchange It is therefore desirable to compare carefully the respective merits of the alternatives before deciding which of them is most advantageous to adopt

Deductions, Allowances and Reliefs

The amount of the assessment in respect of the practice having been decided, it becomes necessary to make a complete return on the well-known buff form The amount liable to assessment should be inserted on page 3, together with any other amounts arising under the other heads shown on that page On page 5 of the form a complete return of all sources of taxed and untaxed income, and of charges thereon, should be furnished to enable the deductions and allowances to be claimed Pages 6 and 7 should also be carefully completed, so that any allowances may be given against the assessment to be made The notice of assessment issued later should agree with the return, provided that the latter is correctly completed On receipt of such notice the sum assessed should be verified carefully, together with the appropriate deductions and allowances, including earned income relief (one-tenth not exceeding £200 up to 1924-25, and one-sixth not exceeding £250 for the years 1925-26 and 1926-27), personal allowance of £135 single, £225 married, and wife to £45 if earning income, child allowance of £36 for first child and each additional £27, housekeeper or widowed mother £45 up to 1923-24, and £60 subsequently, dependent relative £25, first £225 of taxable income at half standard rate, and life assurance premiums from half to full rate according to total income, date of policy and its conditions The period within which to appeal against the assessment is twenty-one days, and where objection is necessary written notice should be given to the Inspector of Taxes before that period expires The notice must state the ground of the appeal More detailed reference will be made to these points at a later stage

There are certain circumstances in which adjustments may be made within or after the end of the year of assessment, in respect of the tax payable for a varying number of years up to 1926-27 (The effect of the Finance Act, 1926, is mentioned later) The following constitute the principal grounds and any adjustment can be made to take effect by way of repayment or of reduction in the outstanding tax

1 Where a change in ownership has occurred within the year, the current year's assessment is apportioned between the former and the current owners of the practice

2 Where owing to the person ceasing to carry on the profession or dying or becoming bankrupt or from any other specific cause (such as where ownership has changed) the profit falls short of the assessed amount, a reduction may be claimed to the actual profit of the year

3 A person succeeding to the practice, or a new partnership, may apply for adjustment to the actual profit in the year of assessment if such profit is less through some specific cause arising since or by reason of the succession or partnership change "Specific cause" includes such occurrences as removal to other premises, or loss of personal influence, but the term is of very wide application, and frequently very difficult to elucidate

4 If the profession has commenced within the last four years a claim may be made for reduction to the actual profit of each year It is not necessary, therefore, in this period to abide by the average figure, and the option of claim is entirely with the tax-payer

5 If the profession is discontinued, a claim may be made to have the assessment of the current year reduced to the actual profit and to have the actual profit of the three previous years substituted for the assessments of those years

6 Where a loss is sustained in the profession, tax on the amount of such loss is recoverable against any tax paid for that year This claim for relief is only advisable in the absence of any other equivalent relief, and then with discrimination, as the loss on which repayment is made is not

allowed in reduction of averages, up to and including 1926-27. It is, however, a distinctly advantageous claim when the rate of tax is falling, as it can readily be seen that a repayment for a year when the tax is high will result in a saving if the loss would otherwise be set against a lower rate of tax in a subsequent year.

7 In the event of it being found that an error or mistake in the return or statement has been made, repayment of tax may be claimed within six years on account thereof.

The foregoing points constitute salient features in the taxation of the profession, but it will be appreciated that the many phases of assessment and allowances are subject to varying conditions and stipulations so that many troublesome points can only be settled as they arise. The many Acts and various textbooks on the subject of Income Tax readily demonstrate the complexity of modern taxation, and probably no field in the fabric of social life is so encumbered with legislative enactments and judicial decisions, not to mention the numerous modifications introduced in practice. The ramifications of taxation are so wide and so deep that even in an extensive accountancy and taxation practice it is an almost unique occurrence to deal with two cases containing precisely similar circumstances and conditions. It is true that members of any one profession may derive help in conforming generally to an approximately standard type of assessment as already outlined, but it is equally true that in the computation of other income, in the statement of charges, and in the claiming of adjustments and allowances they must join the general community of confused and exasperated persons known as "tax-payers."

Verifying the Assessment

Notices of Assessment are issued during the late summer and early autumn months as the books of assessment are completed by the Commissioners, and as it is necessary to give notice of objection within twenty-one days of the date of the notice of assessment the contents should be checked

without delay Attention should be directed not only to the amount of the assessment, but also to the deductions, allowances and reliefs to which reference has already been made As the average medical man is subject to an assessment of a somewhat complex character, it is very necessary that vigilance should be exercised

This will best be achieved by following the order in which the items are stated in the notice of assessment

1 The amount of assessment as shown should accord with the return of profits previously made If there is an increase in the notice an explanation should be asked for, so that the discrepancy may be reconciled It would be well to remember that even if the amount agrees with the return there are a number of somewhat unusual expenses which should have been allowed These expenses should have included such well-known items as rent, rates and water, repairs, assurance, drugs, instruments, bottles, lighting, heating, postages, stationery, telephone, periodicals, textbooks, wages and National Health Insurance Included also in the expenses should have been the cost of car-running (or hire) expenses, whilst the amount allowable in respect of the cost of renewal of any car should have been deducted, unless a claim is made for a wear-and-tear allowance An item liable to be overlooked is the cost of board of locum tenens, whose salary is not so likely to be omitted The cost (or partial cost) of boarding servants, occasional servants, odd man or boy is also presumed to have been allowed The point in connexion with emoluments from public appointments should also receive attention, and in this connexion claim should be made for necessary expenses not recoverable from the public body concerned

2 The notice should show the earned income allowance of one-tenth of the amount of the assessment up to 1924-25 and one-sixth for later years The limit to the amount of this allowance is £200 up to 1924-25 and subsequently £250

3 An age allowance of one-sixth of the total income is substituted in the case of tax-payers of over sixty-five years whose total income does not exceed £500 The relief

operated for the first time in 1925-26. A marginal relief is claimable where the income only slightly exceeds £500.

4 The personal allowance of £135 is given in the case of a single person, whilst £225 is allowed to a married man. An interesting point to watch in this connexion is the allowance of the additional £90 even if married on the last day of the income-tax year. It is still more interesting to note that a claim for refund of income tax on £90 may be made if married before the close of the income-tax year and tax has already been paid for that year when single allowance only had been given.

5 The housekeeper allowance of £45 has been increased to £60 as from April 6, 1924. This allowance is given in respect of persons taking charge of a widower's child, or acting as housekeeper merely, or in respect of a widowed mother having charge of a brother or sister in respect of whom the child allowance is given. Formerly a widower could not claim in respect of a housekeeper unless he had a child being looked after by such housekeeper, but this condition has been repealed.

6 The allowance in respect of children amounts to £36 for the first child, and £27 for each other. The child must have been living on the first day of the year of assessment to enable the allowance to be given in that year, but it must not be assumed that if the child is born later the allowance is lost, for what is foregone in the first year is gained in the last year of claim. There are sixteen annual allowances, and no more, for each child unless, of course, the proviso as to full-time attendance at school beyond the age of sixteen comes into play. Step-children and adopted children are included in the allowance. The allowance is not given for a child with an income of £40 or more, but scholarships are not taken into account.

7 Where a tax-payer maintains a dependent relative whose income does not exceed £50 a year, and who is incapacitated by old age or infirmity from maintaining himself or herself, a deduction of £25 may be claimed. This applies to the widowed mothers of the tax-payer and his wife,

whether those relatives are incapacitated or not. A similar amount is deductible in respect of a daughter resident with the tax-payer, and upon whose services he is compelled to depend by reason of old age or infirmity.

8 After the deductions and allowances have been set against the assessment the net amount becomes taxable. The first £225 of such taxable income is assessed at one-half the full rate in the £, the remainder being at the full rate.

9 When the total tax has been calculated there should be deducted the allowance in respect of life assurance, which varies from half rate to full rate according to the total income.

10 If the first £225 of taxable income includes items already taxed at the source at the full rate, an allowance is made to bring the total deduction to the equivalent of £225 at half rate.

It may be added that if the profit of the practice is less than the total allowances, claims may be made for repayment of tax, in whole or in part, which has been deducted from private income. Such claims may extend over a period of six years.

The Finance Act, 1926

The Finance Act of 1926 affects not only the year 1926-27, but all years from and including 1927-28, subject to succeeding legislation.

The changes are sweeping, but as far as the medical practitioner is concerned, the main alteration is that for 1927-28 and future years the assessment under Schedule "D" will be based upon the results of the year prior to the year of assessment in place of the average of the three prior years. The new scheme includes modification where a profession has been newly set up or commenced, or has been discontinued, or where other sources of profits are acquired or transferred, or where the immediate adoption of the new basis causes hardship. Partnership changes and successions are dealt with in a new manner, and the

relief claimable in respect of losses can be carried forward in so far as it is not fully granted in the year of the loss

Turning to the most obvious alteration, it is enacted that where a tax-payer proves that the profits or gains or income of either of the first two of the three years upon the average of which he would have been charged for the year 1927-28 were less than the profits or gains or income for one year upon an average of the six years preceding those three years, he shall on giving notice in writing to the Inspector not later than the fifth day of October, 1927, that he desires to be so charged, be charged to tax for both the years 1927-28 and 1928-29, in respect of the profits or gains or income arising from that source on the amount on which he would have been charged if the alteration had not been made. It is further provided that for the purpose of the foregoing arrangements a person shall be treated as having been in possession of the source of any profits or gains or income during any year if during that year he was in possession of the source on his own account or the source was in the possession of a partnership of which he was a partner.

In view of the somewhat complicated effects of the change of system it may be well to give an illustration which may be taken as typical. Assume that the profits of the nine years to March 31, 1927, are as under

Year to 31/3/19	£2,400	} Average £2,500
„ „ 31/3/20	2,900	
„ „ 31/3/21	2,800	
„ „ 31/3/22	2,300	
„ „ 31/3/23	2,100	
„ „ 31/3/24	2,500	} Average £2,400
„ „ 31/3/25	2,100	
„ „ 31/3/26	2,200	
„ „ 31/3/27	2,900	

In connexion with the new method, the assessment for 1927-28 would be based on the profits of the year to March 31, 1927, namely £2,900. If, however, the profits of either of the years to March 31, 1925 or 1926, fall below £2,500 (the average of the six years to March 31, 1924) the tax-payer may elect to be charged upon the average of the three years to March 31, 1927, namely £2,400. This

is distinctly to his advantage for the year 1927-28, but if he exercises his option for that year he must also accept the same basis of charge for 1928-29, namely the average of the three years to March 31, 1928. The choice must be made not later than October 5, 1927, at which date it may be quite impossible for the tax-payer to judge whether he would gain or lose by adopting the average basis.

It should be noted that the option may be exercised if either of the first two years which would normally be brought into the three years average for the 1927-28 assessment is less than the average of the six years already mentioned. In the illustration which has been adopted it happens that the condition is fulfilled by each of the first two years of the normal average.

A point worthy of attention is that in certain cases it is possible to forecast for 1928-29 the result of claiming the relief in question. Where accounts are prepared to a date between April 5 and October 5 in each year the profit of any one year of the practice will form the basis of assessment and charge for the income-tax year which ends from eighteen months to two years subsequent to the date of the accounts. Thus the profits shown by accounts for a year to June 30, 1927, would be assessable for 1928-29, unless from the results of the accounts it was evident that the average method would result in the payment of a smaller amount of tax.

The relief is merely transitional and is intended to prevent possible hardship which might arise in any individual case. The option given by the Finance Act, 1926, does not apply to a year subsequent to 1928-29.

In the case of a new practice the assessment is to be based on an appropriate proportion of the profit shown by the first account. The second year will be assessed on a twelve-months' proportion of that profit. In succeeding years the assessment will be made upon the previous year's profits. Upon written application the second year's assessment may be reduced to the actual profit of that year. For this purpose notice must be given to the revenue authori-

ties within twelve months after the end of the year of assessment

Where the practice is permanently discontinued the amount upon which tax is chargeable for the year in which cessation occurs is the profit from the sixth day of April in that year up to the date of cessation, subject to any deductions or set-offs to which the tax-payer may be entitled in respect of losses or under certain rules of Schedule "D" If the assessment for the year prior to the cessation was less than the actual profits made up to April 5 of that year an additional assessment will be made upon the difference

With regard to changes of partnership the Finance Act, 1926, affects medical practitioners in several ways

If at any time after the fifth day of April, 1928, a change occurs in a partnership by reason of retirement or death, or the dissolution of the partnership as to one or more of the partners, or the admission of a new partner, in such circumstances that one or more of the persons who until that time were engaged in the partnership continue to be engaged therein, or a person who until that time was engaged in practice on his own account continues to be engaged in it, but as a partner in a partnership, the tax payable by the person or persons who carry on the practice after that time shall, notwithstanding the change, be computed according to the profits or gains of the practice during the period prescribed by the Income Tax Acts

Where, however, all the persons who were engaged in the practice both immediately before and immediately after the change desire that the tax payable for all years of assessment shall be computed as if the practice had been discontinued at the date of the change, and a new practice had been then set up or commenced, and that the tax so computed for any year shall be charged as if such discontinuance and setting up or commencement had actually taken place, the computation is to be made accordingly To secure this option all persons concerned must give notice to the Inspector of Taxes within three months of the change, the notice to be in writing

A successor whose case does not fall within the above paragraphs is to be treated as having commenced a new practice, the predecessor being considered as if he had discontinued

Another relief forming the subject of an amendment which is to come into operation on the sixth day of April, 1928, may now be described. Where relief has been given under Rule 11 of the Rules of Cases I and II of Schedule "D" in respect of a falling short of the professional profits from some specific cause since or because of a change in or succession to a partnership or persons engaged in the practice, which change or succession takes place within the year 1927-28, the liable tax-payer after such change or succession will be entitled to be charged to tax for the year 1928-29 as if the profession had been set up or commenced on the date of the change or succession. If the tax charged has been paid any overpayment may be recovered. It is essential that notice of a claim under this heading shall be given to the Inspector in writing not later than October 5, 1929.

Regarding losses incurred in the course of carrying on a practice, relief can be obtained under the Income Tax Act, 1918, but the Finance Act, 1926, modifies the manner of the allowance. Where relief cannot be fully given in any one year the balance of the loss can be carried forward and set off against subsequent profits. The limit for such setting off is six years following the year of assessment. It is very unlikely that a loss would be severe enough to require such a long period for recoupment.

As a matter of interest it may be noted that the Finance Act, 1926, refers to the "Surveyor". This is the official more generally known to tax-payers as the "Inspector".

In connexion with an Appeal against an assessment under Schedule "D," it is now requisite that the appellant shall, in his written notice, specify the grounds of the Appeal. Provision is made for an appellant who desires to introduce other grounds of Appeal not specified in the notice, and if the opinion of the Commissioners hearing the Appeal is

that the omission was not wilful or unreasonable they may not preclude the appellant from stating the further grounds and taking them into consideration. As far as the amount of tax appears to be not in dispute payment is required to be made as if no Appeal was pending, and the balance chargeable on the determination of the Appeal becomes payable at once.

The Act under consideration amends Section 24 of the Finance Act, 1923, which gave relief where a tax-payer has made an error in a return or statement. The change consists in the extension of the time for claiming such relief to six years after the end of the year of assessment within which the assessment was made.

It may be noted that the British Government and the Irish Free State have concluded an agreement for the reciprocal exemption from income tax and super tax of persons who are resident in Great Britain (including Northern Ireland) or in the Irish Free State, but are not resident in both countries, and for the reciprocal granting of relief from double taxation in respect of income tax (including super tax) of persons who are resident in both countries.

There is little doubt that the 1926 Act will give rise to a considerable amount of discussion, and that many points will require decision by the courts before definite pronouncements can be made. It should, therefore, be understood that the above résumé is intended to crystallize the position rather than to endeavour to cover any individual case.

Super Tax

In the case of total income exceeding £2,000 super tax becomes payable, the scale of tax ranging from 9d to 6s in the £ for the years 1925-26 and 1926-27.

The chief point to remember in connexion with this tax is that the current year's return is to be based on last year's statutory income, before deduction of income tax or the allowances which form part of the adjustment of that tax. If a super-tax return has been made, and an alteration is subsequently made in the income-tax income

of the previous year, the super-tax returns require amendment, and the tax-payer should see that this is done when the change is favourable to him

It is not necessary to complete a return of total income for both income tax and super tax, as a form can be obtained from the Special Commissioners which obviates the necessity for the double return. The preparation of the super-tax return is not likely to give rise to any great difficulty in the majority of cases ¹

General

If the reader has arrived at the present paragraph by steadily persevering with his initiation into some of the mysteries of taxation he will doubtless have arrived at the conclusion that the subject is far too extensive to be effectively condensed within the compass of a few pages. He may be interested to learn that one standard work on the subject contains over a thousand pages, and that it is but one of many volumes upon the same subject apart from judicial decisions necessitated by the impossibility of definitely construing an Act, a section, or in some instances a word.

The aim of the writer has been to place before the medical practitioner the main lines upon which he may secure a fair and just settlement of his case, and it is hoped that the effort will meet with success. It must, however, be borne in mind that the taxation code of this country is probably the most complicated part of its legislation, and that the highest legal authorities have sometimes failed to arrive at unanimous decisions in cases which have been carried to the House of Lords. When difficult points arise the tax-payer usually finds himself, very naturally, in a state of hopeless confusion, and in those circumstances the best advice that can possibly be given is that he should consult a specialist.

¹ The Finance Bill, 1927, was introduced while these pages were in the press, its proposals, which only affect this Appendix in a special way, have not yet been put into ~~the concrete language~~ of legislation.

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